

Dental Practitioners 2006

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY DENTAL PRACTITIONERS, EFFECTIVE FROM 1 JANUARY 2006		
<p>The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.</p> <p>In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.</p> <p>VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.</p> <p>The existence of a code in this publication does not mean that the procedure will be reimbursed by medical schemes. Medical schemes have the right to limit the scope, the frequency and/or combinations of dental procedures that is covered or reimbursed. It is the responsibility of the patient to know what procedures are covered and what are excluded from his/her dental benefit plan, and not that of the dental office. Certain medical schemes may require predetermination for particular procedures and/or when charges are expected to exceed a certain amount.</p> <p>The schedule includes procedures and services for use by Oral Health Care Providers for purposes of keeping accurate patient records, reporting procedures on patients, and processing oral health care related insurance claims. The procedures are those performed by general dental practitioners, oral pathologists, prosthodontists, periodontists, orthodontists, maxillo-facial and oral surgeons and dental therapists.</p> <p>The procedures codes listed in the schedule have, for the convenience in using the schedule, been divided into categories of services, based on the branches of clinical dental practice. The procedures are grouped under the category of service with which the procedures are most frequently identified and should not be interpreted as excluding certain categories of Oral Health Care Providers from performing such procedures. Individual procedure codes consist of a procedure code, procedure description (nomenclature), and when necessary, a descriptor, that provides further definition and/or guidelines to clarify the intended use of the procedure code.</p>		
I.	INTRODUCTION	
A.	Administrative and invoicing rules	
001	Invoices:	05.02
	a. A practitioner shall render a monthly invoice for every procedure which has been completed irrespective of whether the total treatment plan has been concluded.	05.02
	b. An invoice shall contain the following particulars:	05.02
	i. The surname and initials of the member; ii. The first name of the patient; iii. The name of the scheme; iv. The membership number of the member; v. The practice number; vi. The date on which every service was rendered; vii. The code number, description and fee/benefit of the procedure or service; viii. The name of the dentist rendering the service; ix. The name of the general dental practitioner/specialist assistant (when applicable); x. The appropriate ICD-10 code(s) for the procedures performed.	06.03
	Note: Photocopies of original invoices shall be certified by way of a rubber stamp or the signature of the dentist.	05.02
002	Cost of direct materials: The expenses incurred for direct materials identified in the Schedule may be billed in addition to the procedure code. These expenses are limited to the net acquisition cost of the materials and a handling fee. The price of the materials should be VAT inclusive. Use Modifier 8025 for handling fee.	05.02
003	Dental laboratory services:	05.02
	Manual submission of invoices. Fees charged by dental technicians for laboratory services (PLUS L) shall be indicated on the dentist's invoice by reporting code 8099 - Dental laboratory service with the appropriate laboratory fee on the line following the relevant dental procedure code. The technician's invoice shall be certified by the dentist (or a person appointed by the dentist) for correctness by means of a signature. The original invoice of the dental technician (or a copy thereof) shall accompany the invoice of the dentist and a copy (or the original) shall be filed by the dentist for record purposes.	05.02

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	Electronic submission of invoices. Fees charged by dental technicians for laboratory services (PLUS L) shall be indicated on the dentist's invoice by submitting code 8099 - Dental laboratory service with the appropriate laboratory fee on the line following the relevant dental procedure code on the date on which the dental procedure was rendered. The laboratory fee shall be submitted for payment on the date on which the procedure code is submitted for payment, and the appropriate dental laboratory service codes shall be reported on the lines following code 8099. The technician's invoice shall be certified by the dentist (or a person appointed by the dentist) for correctness by means of a signature. The original invoice of the dental technician shall be filed by the dentist for record purposes.	05.02
005	Procedure accompanied by unusual circumstances: In exceptional cases where the proposed fee/benefit is disproportionately low in relation to the actual services rendered by a practitioner, such higher fee as may be mutually agreed upon between the dental practitioner and the patient/medical scheme may be billed. Use Modifier 8011 with a narrative description. Under certain circumstances a service or procedure is partially reduced or eliminated at the practitioner's election. Under these circumstances a lower fee may be billed. The service provided can be identified by its usual procedure code and the addition of Modifier 8012, signifying the service is reduced.	05.02
B.	General coding rules	
006	The schedule does not prescribe the scope of practice of a particular category of Oral Health Care Provider; neither does it confine the performing of procedures or services to a registered speciality. Fees listed within a column of a particular category of Oral Health Care Provider are customary fees, should the procedure or service be rendered by that provider category. Specialists are however encouraged to confine their practice to the speciality or related specialities in which they are registered. Specialist may charge fees for procedures or services which usually pertain to some other speciality, if such procedures or services are also recognised in their speciality, and if it is carried out only for their bona fide patients. Such fees shall not be higher than those charged by general practitioners for the same procedures or services (HPCSA, Rule 25). Fees for procedures or services not listed within the column of dental therapists that do fall within the field of dental therapy in terms of their scope of practice are regarded as being "by arrangement" until such fees are listed.	06.03
007	Procedures not listed in the Dental Schedule	05.02
	When a procedure is performed that is not listed in the schedule, an appropriate procedure code, listed in the NHRPL for medical practitioners may be reported.	06.03
	Unlisted procedures. Any procedure that is neither described in the schedule, nor in the medical schedule, should be reported using code 9099 - Unlisted dental procedure or service. The fee for an unlisted dental procedure or service should be based on the fee of a comparable procedure. Code 9099 codes should not be used to report procedures where the fee is determined "by arrangement" with the patient and/or medical scheme.	06.03
C.	Services rules	
008	Oral evaluations and completion of treatment plans: Oral examinations include an examination, diagnosis and treatment planning (when treatment is required). No further fees/benefits shall be levied for an oral examination (code 8101) or comprehensive examination (code 8102) until the treatment plan resulting from these type of examinations is completed. The completion of a treatment plan effected from an oral examination and/or comprehensive examination should be indicated by reporting code 8120 – Treatment plan completed. Oral diagnosis defined. The determination by the dentist of the oral health condition of an individual patient achieved through the evaluation of data gathered by means of history taking, direct examination, patient conference, and such clinical aids and tests as may be necessary in the judgement of the dentist. Treatment plan defined. The treatment plan is the sequential guide for the patient's care as determined by the dentist's diagnosis and is used by the dentists for the restoration and/or maintenance of optimal oral health	06.03
009	Surgery guidelines:	05.02
	1. Follow-up care for therapeutic surgical procedures: The fee/benefit for an operation shall, unless otherwise stated, include normal post-operative care for a period not exceeding four months. If a practitioner does not him/herself complete the post-operative care, he/she shall arrange for post-operative care without additional charges. A fee/benefit for post-operative treatment of a prolonged or specialised nature may be charged as agreed upon between the practitioner and the scheme.	05.02
	2. Multiple Procedures (Maxillo-facial and oral surgery): The fee/benefit for more than one operation or procedure performed through the same incision shall be determined as the fee for the major operation plus fee/benefit for the subsidiary operation to the indicated maximum for each such subsidiary operation or procedure (Modifier 8005). The fee/benefit for more than one operation or procedure performed under the same anaesthetic but through another incision shall be determined on the fee/benefit for the major operation plus: 75% for the second procedure/operation (Modifier 8009). 50% for the third and subsequent procedures/operations (Modifier 8006). This rule shall not apply where two or more unrelated operations are performed by practitioners in different specialities, in which case each practitioner shall be entitled to the full fee/benefit of the operation. If, within four months, a second operation for the same condition or injury is performed, the fee/benefit for the second operation shall be 50% of that of the first operation (Modifier 8006).	05.02
	3. Assistant Surgeon (Maxillo-facial and periodontal surgery): The fee payable to a specialist assistant is determined as 1/3 (of the fee of the practitioner performing the procedure (Modifier 8001). The fee payable to a general dental practitioner assistant is determined as 15% (of the fee of the practitioner performing the procedure (Modifier 8007). The patient must be informed beforehand that another dentist/specialist will be assisting at the operation and that a fee will be payable to the assistant. The assistant's name must appear on the invoice rendered to the patient.	05.02

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	4. Surgical team (Maxillo-facial and oral surgery): The additional fee to all members of the surgical team for after hours emergency surgery shall be calculated by adding 25% to the fee for the procedure or procedures performed (Modifier 8008).	05.02
010	Orthodontic guidelines:	05.02
	The documentation and first invoice to the patient/medical scheme regarding orthodontic services will include the following information: a. The treatment plan and type of treatment (treatment code number); b. A diagnostic code (ICD-10) and c. An orthodontic payment plan indicating the following: i. The total fee that will be levied for the treatment; ii. The total months of orthodontic treatment (retention period excluded); iii. The initial fee payable by the patient (approximately 20% of the total fee); and iv. The monthly payments of the balance of the fee.	06.03
	2. The fee for orthodontic treatment does not include a clinical oral evaluation and necessary diagnostic services. The fee for corrective therapy (i.e. codes 8861 to 8888) is an inclusive fee and no additional fees may be levied for intra-operative oral evaluations and preventive services. A pre-orthodontic treatment visit, an orthodontic retention, and an oral evaluation on completion of the treatment plan (retention phase included) are excluded and should be reported in addition to corrective orthodontic treatment as separate procedures (Code 8803 x3). Intra/post orthodontic treatment records consisting of radiographs/diagnostic images (limited to a cephalometric film and 5 oral/facial images) and diagnostic casts may be levied when a corrective orthodontic treatment plan is completed (retention phase included).	05.02
	3. The fee for 'Fixed appliance therapy' (codes 8861 and 8865 to 8888), as determined by the individual practitioner, will be levied on a monthly manner over the treatment period (retention phase excluded).	05.02
	4. When partial fixed appliance or preliminary orthodontic treatment (codes 8858, 8861, 8865 or 8866) is followed by full fixed appliance orthodontic treatment (codes 8873 to 8888) provided by the same orthodontist, the fees levied for the partial fixed appliance therapy or preliminary treatment will be deducted from the fee quoted for the full fixed appliance orthodontic treatment.	05.02
	5. The total fee for multiple phases of full fixed appliance orthodontic treatment provided by the same orthodontist may not exceed the most recent fee (determined on commencement date of the final stage of full fixed appliance treatment) for the appropriate full fixed orthodontic procedure.	05.02
	6. When the patient transfers to another practitioner during treatment, or treatment is terminated for any reason, the original treating practitioner must report the number of treatment months remaining and determine the balance of the fee by applying the following formula: Total payment (for treatment only) minus 20% of the total fee (for banding - when applicable) multiplied by the percentage of treatment remaining. For example, if the practitioner was paid R 10,000.00 for a 24-month treatment plan and 18 months of treatment were completed. The balance would be R 2,000.00 (or R 10,000.00 - R 2,000.00 x 6/24). The length of the treatment plan from the original request for authorisation will be used to determine the number of treatment months remaining. The practitioner continuing treatment will provide the information stipulated in paragraph 1 above. Report code 8891 (Orthodontic transfer) with the fee that will be levied for continuation of the treatment in addition to the appropriate orthodontic treatment code. The fee for continuous treatment is subject to prior authorisation by the patient's medical scheme.	05.02
	7. When an established orthodontic patient requires re-treatment, the information stipulated in paragraph 1 above and the cause(s) for re-treatment will be provided. Report code 8892 (Orthodontic re-treatment) with the fee that will be levied for re-treatment in addition to the appropriate orthodontic treatment code. Orthodontic re-treatment is subject to prior authorisation by the patient's medical scheme.	05.02
011	Dento-legal fees: Practitioners are entitled to remuneration if they are present at Court at the request of an advocate or attorney. Use code 8111 (Dental testimony) to report dento-legal work. The code is listed in the adjunctive general services sections in the code lists.	05.02
D.	Modifiers	
012	Modifiers: Modifiers should be used with procedures identified throughout the NHRPL. Modifiers provide the means by which the reporting practitioner can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed its definition or code. The sensible application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance. Modifiers may be used to indicate to the recipient of the report that: a. A service or procedure was performed by more than one practitioner. b. A service or procedure has been increased or reduced. c. Only part of a service was performed. d. An adjunctive service was performed. e. A service or procedure was provided more than once. f. The fee/benefit was altered due to a financial agreement.	06.03
8001	Assistant surgeon - specialist (1/3 of the appropriate benefit)	06.03
8003	Minimum assistant surgeon	06.03
		117.93 (103.45)
		117.93 (103.45)
		117.93 (103.45)

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	The minimum fee/benefit for surgical assistant services is identified by adding Modifier 8003 to the primary procedure code – See Rule 009.									
8005	Maximum multiple procedures (same incision) - MFO surgeon	06.03	183.09 (160.61)	183.09 (160.61)		183.09 (160.61)				
	When multiple surgical procedures through the same incision are performed on the same day or at the same session by the same provider, the primary procedure may be reported as listed. The maximum fee/benefit for each additional procedure should be identified by adding Modifier 8005 to the additional procedure code.									
8006	Multiple surgical procedures - third and subsequent procedures (50% of the appropriate benefit)									06.03
8007	Assistant surgeon - general dental practitioner (15% of the appropriate benefit)									06.03
8008	Emergency surgery - after hours (PLUS 25% of the appropriate benefit)									06.03
8009	Multiple surgical procedures - second procedure (75% of the appropriate benefit)									06.03
8010	Open reduction (PLUS 75% of the appropriate benefit)									06.03
8011	Procedure accompanied by unusual circumstances (Benefit PLUS X % as determined by the practitioner and agreed upon by patient/medical scheme)									06.03
8012	Reduced services (benefit MINUS X % as determined by the practitioner)									06.03
8013	Multiple modifiers									06.03
8023	Fabrication of inlay/onlay (PLUS 25% of the appropriate benefit)									06.03
8025	Handling fee - direct materials (26% of material cost to a maximum of R26.00)	06.03	-	-		-	-			
	When listed direct dental materials are provided by the practitioner, a handling fee may be levied by reporting Modifier 8025 in addition to the appropriate direct material code – See Rule 002.									
E.	Explanations									
Tooth identification and designation of areas of the oral cavity:										
	Tooth identification and designation of areas of the oral cavity is compulsory for all invoices rendered. Tooth identification is applicable to procedures identified with the letter (T), and other designation of areas of the oral cavity with the letter (Q) for a quadrant and the letter (M) for the maxillary or mandibular area in the mouth part (MP) column of the Dental Coding. The International Standards Organisation (ISO) in collaboration with the FDI designated system for teeth and areas of the oral cavity should be used. For supernumeraries, the abbreviation SUP should be used.									04.00
Treatment categories:										
	Treatment categories (TC) of dental procedures are identified in the TC column of the Dental Coding as follows: Basic dentistry - designated as (B) in the treatment category column Advanced dentistry - designated as (A) in the treatment category column Surgery - designated as (S) in the treatment category column									04.00
Abbreviations used in Dental Coding										
	DM	Direct Material Column								05.02
	+D	Add fee/benefit for denture								
	+L	Add laboratory fee								
	+M	Add material fee								
	MP	Mouth Part Column								05.02
	M	Maxilla/Mandible								
	Q	Quadrant								
	S	Sextant								
	T	Tooth								
	TC	Treatment Category Column								05.02
	A	Advanced dentistry								
	B	Basic dentistry								
	S	Surgery								

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	Practice type codes: 25400 General Dental Practitioner 26200 Specialist Maxillo Facial and Oral Surgeon 26400 Specialist Orthodontist 29200 Specialist in Oral Medicine and Periodontics 29400 Specialist Prosthodontist 29800 Specialist Oral Pathologist 39500 Dental Therapist	06.03									
F.	Guidelines to medical schemes										
	Age of a Child. The determination of a child or adult status of the patient should be based on the clinical development of the patient's dentition. Where administrative constraints preclude the use of clinical development so that the chronological age must be used to determine the child or adult status, the patient is defined as an adult beginning at age 12 with the exclusion of treatment for orthodontics or sealants.	05.02									
	Frequency of benefits. The South African Dental Association recommends to medical schemes, where considered necessary and appropriate, that contract limitations on the frequency of providing care for certain services be stated as “twice a calendar year” rather than once in every six months.	05.02									
	Radiographs and records. Radiographs should be taken only for clinical reasons as determined by the treating dentist. Postoperative radiographs should only be required as part of dental treatment. When a dentist determined it is appropriate to comply with a third-party payer's request for radiographs, a duplicate set should be submitted and the originals retained by the dentist. Any additional costs incurred by the dentists in copying radiographs and clinical records for claims determination should be reimbursed by the third-party payer or the patient.	05.02									
	New vs. established patient. A new patient is one who has not received any professional services from the dentist or another dentist of the same speciality who belongs to the same group practice, within the past three years. An established patient (patient of record) is one who has received professional services from the dentist or another dentist of the same speciality who belongs to the same group practice, within the past three years. In the instance where a dentist is on call for or covering for another dentist, the patient's encounter will be classified as it would have been by the dentist who is not available.	05.02									
II.	DENTAL PROCEDURES AND SERVICES										
A.	DIAGNOSTIC SERVICES										
	The branch of dentistry used to identify and prevent dental disorders and disease. Includes all services/procedures available to the dentist for evaluating existing conditions and determining any further dental care that may be required.	06.03									
CLINICAL ORAL EXAMINATIONS											
	The purpose of oral examinations is to observe and record pertinent information, past and present, necessary to arrive at a diagnosis and treatment plan (when treatment is indicated). A treatment plan is a list of procedures or services the dentist proposes to perform on a dental patient based on the results of the examination and diagnosis. Often more than one treatment plan is presented. Oral examinations may require the integration of information that is acquired through additional diagnostic procedures, which should be reported separately. The oral examination, diagnosis, and treatment planning are the responsibility of the dentist. The collection and recording of some data and components of the oral examination may however be delegated. Oral examinations and consultations include the issuing of prescriptions where medication is required.	06.03									
General Dental Practitioner											
Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontic s	Oral Medicine and Periodontics	Prosthodont ics	Oral Pathology	M P	Lab	T C
8101	Oral examination	06.03	103.50 (90.80)								B

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	<p>An assessment performed on a patient to determine the patient's dental and medical health status involving an examination, diagnosis and treatment plan.</p> <p>It is a thorough assessment and recording of the patient's current state of oral health (extraoral and intraoral hard and soft tissues), risk for future dental disease as well as assessing general health factors that relate to the treatment of the patient.</p> <p>This procedure is also used to report a periodic examination on an established patient to determine any changes in a patient's dental and medical health status since a previous periodic or comprehensive examination.</p> <p>No further oral examination fees shall be levied until the treatment plan resulting from this assessment is completed (See Rule 008).</p>									
8102	Comprehensive oral examination	06.03	167.20 (146.70)							B
	<p>An assessment performed on a new or established patient (patient of record) to determine the patient's dental and medical health status involving a comprehensive examination, diagnosis and treatment plan.</p> <p>It is a thorough assessment and recording of the patient's past and current state of oral health (extraoral and intraoral hard and soft tissues), risk for future dental disease as well as assessing general health factors that relate to the treatment of the patient.</p> <p>A comprehensive examination includes treatment planning at a separate appointment where a diagnosis is made with information acquired through study models, full-mouth x-rays and other relevant diagnostic aids. It includes, but is not limited to the evaluation and recording of dental caries, pulp vitality tests of the complete dentition, plaque index, missing and unerupted teeth, restorations, occlusal relationships, periodontal conditions (including a periodontal charting and bleeding index), hard and soft tissue anomalies (including the TMJ).</p> <p>The patient shall be provided with a written comprehensive treatment plan, which is a part of the patient's clinical record and the original should be retained by the dentist.</p> <p>No further oral examination fees shall be levied until the treatment plan resulting from this assessment is completed (See Rule 008)</p>									
8104	Limited oral examination	06.03	50.20 (44.00)							B
	<p>An assessment performed on a new or established patient (patient of record) involving an examination, diagnosis and treatment plan, limited to a specific oral health problem or complaint. This type of assessment is conducted on patients who present with a specific problem or during an emergency situation for the management of a critical dental condition (e.g., trauma and acute infections). It includes patients who have been referred for the management of a specific condition or treatment such as the removal of a tooth, a crown lengthening or isolated grafting procedure where there is no need for a comprehensive assessment.</p> <p>Comment: This code should not be reported on established patients who present with specific problems/emergencies which is part of and/or a result of the patients' current treatment plan, e.g., recementation/replacement of temporary restorations, pain relief during root canal treatment, etc.</p>									
8189	Re-examination - existing condition	06.03	50.20 (44.00)							B
	<p>An assessment performed on an established patient (patient of record) to assess the status of an untreated previously existing condition involving an examination and evaluation, limited to the previously existing condition.</p> <p>This type of assessment is conducted on patients (1) with a traumatic injury where no treatment was rendered but the patient needs follow-up monitoring; (2) requires evaluation for undiagnosed continuing pain after a limited oral examination and diagnostic tests did not reveal any findings; and (3) with soft tissue lesions such as a leukoplakia observed on a previous visit that require follow-up monitoring of pathological changes.</p> <p>Comment: (1) A re- examination is not a post-operative visit.</p>									
8176	Periodontal screening	06.03	87.20 (76.50)							B

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	Periodontal screenings include but are not limited to a periodontal charting of the complete dentition; plaque index and bleeding index. The findings should be recorded, is a part of the patient's clinical record and should be retained by the dentist.										
8190	Consultation - second opinion or advice	06.03		103.50 (90.80)							B
	A consultation is a diagnostic service rendered by a dentist, other than the practitioner providing treatment, whose opinion or advice for the purpose of determining the patient's dental needs and proposing treatment regarding a specific problem is requested. A consultation requires and includes a written report to the practitioner or patient who requested the consultation. It involves an examination, diagnosis and treatment proposal. The dentist may initiate further diagnostic or therapeutic services (oral examinations excluded). Comment: A referral is the transfer of the total or specific care of a patient from one dentist to another and does not constitute a consultation. When the consulting dentist assumes responsibility for the continuing care of the patient, any service rendered by him/her will cease to be a consultation, and an appropriate oral examination code should be reported. Code 8106 (special report) may not be reported in addition to this code										
Maxillo Facial Surgeon											
8901	Consultation - MFOS	04.00		131.90 (115.70)							S
8902	Consultation - MFOS (detailed)	06.03		345.20 (302.80)							S
	Detailed clinical examination, radiographic interpretation, diagnosis, treatment planning and case presentation. Code 8902 is a separate procedure from code 8901 and is applicable to craniomandibular disorders, implant placement and orthognathic and maxillofacial reconstruction.										
8840	Treatment planning for orthognathic surgery - ALL	06.03	297.90 (261.30)	446.80 (391.90)	446.80 (391.90)					+L	S
	In the case of treatment planning requiring the combined services of a Prosthodontist and/or Orthodontist and/or a Maxillo-Facial and Oral Surgeon, Modifier 8009 (75%) may be applied to the fee charged by each specialist.										
Orthodontist											
8801	Consultation - Orthodontist	04.00		131.90 (115.70)							A
8803	Consultation - Orthodontis (subsequent, retention and post treatment)	04.00		76.80 (67.40)							A
8837	Diagnosis and treatment planning - Orthodontist	04.00		61.20 (53.70)							A
Periodontist/Oral Medicine											
	Codes 8701, 8703, 8705 and 8707 cannot be charged at one and the same visit.									06.03	
8701	Consultation - periodontist	06.03				131.90 (115.70)					A
	A periodontal consultation comprises a reasonably detailed examination and presentation and explanation of the findings to enable the patient to make a decision as to future treatment.										
8703	Consultation - Periodontist (detailed)	06.03				345.20 (302.80)					A
	Detailed clinical examination, records, radiographic interpretation, probing, percussion, diagnosis, treatment planning and case presentation for periodontal and/or implant cases. Code 8703 is always a separate procedure from code 8701 and comprises inspection, percussion, probing and other diagnostic procedures and the systematic recording of every important feature in order to permit correct treatment planning.										

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8705	Re-examination - Periodontist	04.00					103.20 (90.50)				A
8707	Periodontal screening - Periodontist	06.03					103.20 (90.50)				A
	A periodontal screening consists of the measurement and recording of a plaque index, a bleeding index, probing depths, a periodontal disease index, a microbiological assay and/or gingival crevicular fluid assay.										
8781	Consultation - Oral medicine (simple)	06.03					103.20 (90.50)				S
	Consultation, examination, diagnosis and treatment of oral diseases, pathological conditions of the surrounding tissues, temporomandibular joint disorders or myofascial pain-dysfunction - Straight forward case										
8782	Consultation - Oral medicine (complex)	06.03					181.50 (159.20)				S
	Consultation, examination, diagnosis and treatment of oral diseases, pathological conditions of the surrounding tissues, temporomandibular joint disorders or myofascial pain dysfunction - Complex case										
8783	Consultation - Oral medicine (subsequent)	06.03					76.80 (67.40)				S
	Subsequent consultation for same disease/condition.										
Prosthodontist											
8501	Consultation - Prosthodontist	04.00					131.90 (115.70)				A
8507	Comprehensive consultation - Prosthodontist	06.03					211.80 (185.80)				A
	Examination, diagnosis and treatment planning.										
8506	Detailed consultation - Prosthodontist	06.03					345.20 (302.80)				A
	Detailed clinical examination, records, radiographic interpretation, diagnosis, treatment planning and case presentation. Code 8506 is a separate procedure from 8507 and is applicable to craniomandibular disorders, implant placement or orthognathic surgery where extensive restorative procedures will be required. Note (Applicable to prosthodontists only - SADA's Dental Coding): In the case of treatment planning requiring the combined services of a Prosthodontist and/or Orthodontist and/or a Maxillo-Facial and Oral Surgeon, Modifier 8009 (75%) may be applied to the fee charged by each specialist - See code 8840 for all other providers.										
Oral Pathologist											
9201	Consultation - oral pathologist	04.00						131.90 (115.70)			
9205	Consultation - oral pathologist (subsequent)	04.00						76.80 (67.40)			

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RADIOGRAPHS/DIAGNOSTIC IMAGING											
	Diagnostic radiographs/diagnostic images include interpretation. Radiographs/diagnostic images should only be taken for clinical reasons as determined by the dentist and practitioners should comply with the Regulations concerning safe radiological practice and take the necessary precaution to minimise radiation of patients. Radiographs/diagnostic images are part of the patient's clinical record, should be of diagnostic quality, properly identified and dated. The dentist should retain the original images and only copies should be used to fulfil requests made by patients or third party funders. A complete series of intra-oral radiographs/images for diagnostic purposes is required once per treatment plan only. A second series may be required in exceptional cases e.g., following periodontal surgery. The same applies to panoramic films, where additional films may be required for follow-up/re-evaluation purposes. Diagnostic radiographs/diagnostic images preceding endodontic treatment, periodontal treatment, the surgical extraction of teeth or roots and fixed prostheses are fundamental to ethical clinical practice.										06.03
8107	Intraoral radiograph - periapical	06.03	41.90 (36.80)	41.90 (36.80)	41.90 (36.80)	41.90 (36.80)	41.90 (36.80)				B
	Eight and more radiographs of any combination of Codes 8107 and 8112 taken on the same date of service for diagnostic purposes are considered to be a complete intraoral series (8108) and should be submitted as such.										
8108	Intraoral radiographs - complete series	06.03	324.30 (284.50)	324.30 (284.50)	324.30 (284.50)	324.30 (284.50)	324.30 (284.50)				B
	A complete series consists of a minimum of eight intraoral radiographs, periapical and or bitewing, occlusal radiographs excluded.										
8112	Intraoral radiograph - bitewing	06.03	41.90 (36.80)	41.90 (36.80)	41.90 (36.80)	41.90 (36.80)	41.90 (36.80)				B
	Eight and more radiographs of any combination of Codes 8107 and 8112 taken on the same date of service for diagnostic purposes are considered to be a complete intraoral series (8108) and should be submitted as such.										
8113	Intraoral radiograph - occlusal	04.00	72.20 (63.30)	72.20 (63.30)	72.20 (63.30)	72.20 (63.30)	72.20 (63.30)				B
8114	Extraoral radiograph - hand-wrist	06.03	167.50 (146.90)	167.50 (146.90)	167.50 (146.90)	167.50 (146.90)	167.50 (146.90)				B
	Use to report extraoral radiographs such as hand-wrist radiographs.										
8115	Extraoral radiograph - panoramic	04.00	167.50 (146.90)	167.50 (146.90)	167.50 (146.90)	167.50 (146.90)	167.50 (146.90)				B
8116	Extraoral radiograph - cephalometric	05.02	167.50 (146.90)	167.50 (146.90)	167.50 (146.90)	167.50 (146.90)	167.50 (146.90)				B
8118	Extraoral radiograph - skull/facial bone	05.02	167.50 (146.90)	167.50 (146.90)	167.50 (146.90)	167.50 (146.90)	167.50 (146.90)				B
8121	Oral and/or facial image (digital/conventional)	06.03	45.00 (39.50)	45.00 (39.50)	45.00 (39.50)	45.00 (39.50)	45.00 (39.50)				B
	This includes traditional photographs and digital intra- or extraoral images obtained by intraoral cameras. These images should only be reported when taken for clinical/diagnostic reasons and shall be retained as part of the patient's clinical record. Excludes conventional radiographs.										
OTHER DIAGNOSTIC PROCEDURES											
8117	Diagnostic models	06.03	45.00 (39.50)	45.00 (39.50)	45.00 (39.50)	45.00 (39.50)	45.00 (39.50)			+L	B
	Also known as study models or diagnostic casts. Models used to aid diagnosis and treatment planning. Diagnostic models should be retained as part of the patient's clinical record and may only be used for diagnostic purposes. Includes diagnostic models mounted on a hinge articulator.										
8119	Diagnostic models mounted	06.03	113.20 (99.30)	113.20 (99.30)	113.20 (99.30)	113.20 (99.30)	113.20 (99.30)			+L	B
	See code 8117. Report this code when models are mounted on a movable condyle articulator.										
8122	Microbiological studies	06.03									B

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	Studies performed to determine pathological agents. May include, but is not limited to tests for susceptibility to periodontal disease. Report per visit. A perio risk assessment report must be made available at no cost when requested.										
8123	Caries susceptibility tests (By Arrangement)	06.03	46.80 (41.10)								B
	A caries susceptibility test is a diagnostic test for determining a patient's saliva pH with a litmus strip to evaluate the patient's propensity for caries. This code should not be used for a caries detectability test (carious dentine staining), which is performed to determine if all the caries has been removed. A caries risk assessment report must be made available at no cost when requested.										
8124	Pulp tests	06.03	12.40 (10.90)								
	Diagnostic tests to determine clinical pulp vitality and/or abnormality. Includes traditional pulp testing methods such as thermal and electronic pulp testing as well as the use of optical devices to detect the blood supply of the pulp. The tests involve multiple teeth and contra-lateral comparison(s), as indicated. Report per visit.										
8503	Occlusion analysis mounted	04.00	141.10 (123.80)				211.80 (185.80)				A
8505	Pantographic recording	04.00	204.80 (179.60)				307.20 (269.50)				A
8508	Electrognathographic recording	04.00	219.30 (192.40)				329.00 (288.60)				A
8509	Electrognathographic recording with computer analysis	04.00	364.10 (319.40)				546.10 (479.00)				A
8811	Tracing and analysis of extra-oral film	04.00	19.40 (17.00)	19.40 (17.00)	19.40 (17.00)	19.40 (17.00)	19.40 (17.00)				B
8839	Diagnostic setup (orthodontics)	04.00	86.40 (75.80)			129.60 (113.70)					A
B. PREVENTIVE SERVICES											
	Services/procedures intended to eliminate or reduce the need for future dental treatment.										06.03
DENTAL PROPHYLAXIS											
8155	Polishing - complete dentition	06.03	63.60 (55.80)			87.60 (76.80)	63.60 (55.80)				B
	A polishing involves the removal of stains and plaque from the clinical crowns of natural teeth, and making the surface smooth and glossy, to help minimise the loss of enamel and decrease the possibility of damage to restorations. Includes the complete primary, transitional or permanent dentition. This code should not be used concurrent with codes 8159 or 8160. See code 8157 in the restorative section for the re-burnishing and polishing of restorations.										
8159	Prophylaxis - complete dentition	06.03	124.90 (109.60)			176.10 (154.50)	124.90 (109.60)				B
	A prophylaxis involves a series of procedures whereby calculus, stain, and other accretions are removed from the clinical crowns of teeth. A prophylaxis includes, but is not limited to a scaling and polishing of the complete primary, transitional or permanent dentition. Code 8159 should not be used concurrent with code 8155 or 8160.										
8160	Removal of gross calculus	06.03									B
	This procedure is used when profuse bleeding prevents immediate polishing. May not be used concurrent with any other prophylactic procedure on the same day.										
8179	Polishing - complete dentition (periodontally compromised patient)	06.03	72.90 (63.90)								B

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	A periodontally compromised patient is defined as a patient presenting with either chronic adult periodontitis, juvenile periodontitis or rapidly progressive periodontitis, confirmed by a CPITN index of 3 or 4. The diagnosis is made with information acquired from at least a periodontal screening (code 8176) and CPITN index, or a comprehensive oral evaluation (code 8102). This diagnosis must be reviewed within a period of three years by means of a periodontal screening (code 8176).										
8180	Prophylaxis - complete dentition (periodontally compromised patient)	06.03	135.70 (119.00)								B
	Comment: See code 8177 descriptor; Include codes 8155 (Polishing – complete dentition), 8159 (Prophylaxis – complete dentition) and 8179 (Plaque removal – periodontal compromised pst). Code 8180 should not be used concurrent with codes 8179.										
TOPICAL FLUORIDE TEATMENT											
	Topical fluoride treatment procedures involve the professionally application of topical fluoride within the dental office. Excludes fluoride application as part of prophylaxis paste, fluoride rinses or "swish." For application of desensitising medicaments, see codes 8166 and 8167 in the supplementary section.									06.03	
8161	Topical application of fluoride - child	06.03	63.60 (55.80)				63.60 (55.80)	63.60 (55.80)			B
	To be used for treatment of complete dentition to prevent dental decay. Report code 8167 in the miscellaneous section when fluoride is used as desensitising medicament. Should not be used concurrent with code 8167. A patient is defined as an adult beginning at age 12.										
8162	Topical application of fluoride - adult	06.03	63.60 (55.80)				63.60 (55.80)	63.60 (55.80)			B
	See code 8161.										
SPACE MAINTENANCE (PASSIVE APPLIANCES)											
	Passive appliances are designed to prevent tooth movement.									06.03	
8173	Space maintainer - fixed, per abutment	05.02	118.00 (103.50)							T +L	B
8175	Space maintainer - removable	04.00	152.10 (133.40)							+L	B
OTHER PREVENTIVE PROCEDURES											
8149	Nutritional counselling	06.03									B
	Involves a dietary habit and food selection analysis, and providing of advice and guidance to the patient and/or patient's family on dietary habits and food selection as part of treatment and control of dental decay and periodontal disease. Comment: (1) The need for nutritional counselling must be confirmed by a caries/perio risk assessment (See also codes 8122 and 8123). (2) A dietary habit analysis and food selection programme must, on request, be made available at no charge. (3) Certain funders do not provide benefits for nutritional counselling for the control of dental disease.										
8150	Tobacco counselling	06.03									B
	Involves the providing of advice, guidance and support services to the patient on tobacco cessation to prevent and control the development of tobacco related oral diseases and conditions and improve prognosis for certain dental treatments. Limitation: (1) The need for tobacco counselling must be confirmed by a caries/perio risk assessment (See also codes 8122 and 8123). (2) If requested, a tobacco prevention and cessation services programme must be made available at no charge. (3) Treatment should be reserved for those persons who are not able to quite using tobacco by using basic intervention methods. Persons are only eligible for this treatment if a documented quit date has been established. Tobacco cessation is limited to 10 services. (4) Certain funders do not provide benefits for tobacco cessation treatment interventions.										

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8151	Oral hygiene instruction	06.03	63.60 (55.80)			127.20 (111.60)	127.20 (111.60)				B
	The dental knowledge of the patient/parent to prevent oral diseases should be evaluated before oral hygiene instructions is provided e.g., do they know what is dental plaque, how can it be removed, what is fluoride, how does fluoride work to prevent dental caries, how can fluoride be used and what is a dental sealant. An oral hygiene instruction may include, but is not limited to: Plaque control information, e.g. instruction pamphlets or leaflets; Dietary instructions; Explanation and demonstration of plaque control (brushing and flossing); Self-practice session in the mouth under professional supervision; Use of special aids such as disclosing agents; and Scoring of plaque levels (plaque index). The patient must be informed prior to the service being rendered that a fee will be levied for oral hygiene instruction. Oral hygiene instructions to a child should take place in the presence of a parent and/or guardian.										
8153	Oral hygiene instruction - each additional visit	06.03	46.60 (40.90)			61.20 (53.70)	61.20 (53.70)				B
	Report code 8153 when additional oral hygiene instructions is required as part of the treatment plan. No other preventive services may be reported at the same visit. See code 8151										
8163	Dental sealant	06.03	41.90 (36.80)				41.90 (36.80)		T		B
	Also known as pit-and fissure sealant. This procedure involves the mechanical and/or chemical preparation of an occlusal enamel surface and placement of a material to seal decay-prone pits, fissures, and grooves of a tooth. A preventive resin restoration is distinguished from a sealant in that in a restorative the decay penetrates into dentin. If the caries is limited to the enamel, it is still considered a sealant. Limitation: Certain funders limit benefits for sealants to two teeth per quadrant.										
8169	Occlusal guard	06.03	244.30 (214.30)							+L	B
	A removable intraoral appliance that is designed to cover the occlusal and incisal surfaces of the teeth of a dental arch to minimise the effects of bruxism (grinding) and other occlusal factors.										
8171	Mouth guard	06.03	73.90 (64.80)							+L	B
	A flexible intraoral appliance that is worn during participation in contact sports to reduce the potential for injury to the teeth and associated tissue. Limitation: Benefit by arrangement.										
8177	Oral hygiene instruction (periodontally compromised patient)	06.03	96.20 (84.40)								B
	A periodontally compromised patient is defined as a patient presenting with either chronic adult periodontitis, juvenile periodontitis or rapidly progressive periodontitis, confirmed by a CPITN index of 3 or 4. The diagnosis is made with information acquired from at least a periodontal screening (code 8176) and CPITN index, or a comprehensive oral evaluation (code 8102). This diagnosis must be reviewed within a period of three years by means of a periodontal screening (code 8176). Comment: The patient must be informed prior to the service being rendered that a fee will be levied for oral hygiene instruction. Includes code 8151 (Oral hygiene instructions)										
8178	Oral hygiene instruction - each additional visit (periodontally compromised patient)	06.03	52.00 (45.60)								B
	See code 8177.										

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C. RESTORATIVE SERVICES											
	The branch of dentistry that deals with the reconstruction of the hard tissues of a tooth or group of teeth, injured or destroyed by trauma or disease. Restorative services/procedures intend to restore the function of a natural tooth. Anterior teeth include incisors and canines. Posterior teeth include premolars and molars. The number of tooth surfaces restored, i.e. mesial, occlusal (or incisal), distal, lingual, or vestibular (buccal or labial), is used to determine the appropriate procedure code. A one surface restoration for example, involves only one of the surfaces, while a two-surface restoration extends to two of the five surfaces. With a four-or-more-surfaces anterior restoration involving four tooth surfaces and the incisal angle is involved. Limitations on amalgam and resin-based composite restorations: (1) The reporting of two separate restorations of the same material (e.g., a MO and DO amalgam restoration) on the same tooth is appropriate. Some medical schemes however, have a clause in its dental plan(s) that restricts coverage of the same tooth surface, such as an occlusal, twice on the same day and may require the reporting of a MOD restoration instead of a separate MO and DO restoration. (2) The current NHRPL rates include direct pulp capping (code 8301) and rubber dam application (code 8304).										06.03
AMALGAM RESTORATIONS											
	All adhesives, liners, bases and polishing are included as part of the restoration. If pins are used, they should be reported separately. See codes 8345, 8347 and 8348 for post and/or pin retention.										06.03
8341	Amalgam - one surface	04.00	126.50 (111.00)						T		B
8342	Amalgam - two surfaces	04.00	155.90 (136.80)						T		B
8343	Amalgam - three surfaces	04.00	190.00 (166.70)						T		B
8344	Amalgam - four or more surfaces	04.00	211.80 (185.80)						T		B
RESIN-BASED COMPOSITE RESTORATIONS											
	Resin restorations refer to a broad category of materials including but not limited to composites. Report these codes when glass ionomers/compomers are used as restorations. The procedures include acid etching, adhesives (including resin bonding agents) and curing part of the restoration. Resin restorations utilise the direct technique. For the indirect technique, see "Resin inlays/onlays" If pins are used, they should be reported in addition to these codes - See codes 8345, 8347 and 8348 for post and/or pin retention.										06.03
8350	Resin crown - anterior primary tooth (direct)	06.03	275.90 (242.00)						T		B
	This procedure involves the full coverage of an anterior primary tooth with a resin based material.										
8351	Resin - one surface, anterior	04.00	138.80 (121.80)						T		B
8352	Resin - two surfaces, anterior	04.00	174.60 (153.20)						T		B
8353	Resin - three surfaces, anterior	04.00	208.70 (183.10)						T		B
8354	Resin - four or more surfaces, anterior	06.03	232.70 (204.10)						T		B
	Use to report the involvement of four or more surfaces or the incisal line angle. The Incisal line angle is the junction of the incisal and the mesial or distal surface of an anterior tooth.										
8367	Resin - one surface, posterior	06.03	150.50 (132.00)						T		B
	This is not a preventative procedure and should only be used to restore a carious lesion or a deeply eroded area into a natural tooth. See also code 8163 - sealant.										
8368	Resin - two surfaces, posterior	04.00	186.20 (163.30)						T		B

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8369	Resin - three surfaces, posterior	04.00	225.00 (197.40)						T		B
8370	Resin - four or more surfaces, posterior	04.00	242.00 (212.30)						T		B
GOLD FOIL RESTORATIONS											
8561	Gold foil class I or IV	04.00	368.30 (323.10)				552.30 (484.50)		T		A
8563	Gold foil class V	04.00	430.80 (377.90)				646.20 (566.80)		T		A
8565	Gold foil class III	04.00	542.00 (475.40)				813.00 (713.20)		T		A
INLAY/ONLAY RESTORATIONS											
	Temporary and/or intermediate inlays/onlays, the removal thereof and cementing of the permanent restoration are included as part of the restoration. The cusp tip must be overlaid to be considered an onlay.										06.03
Metal Inlays/Onlays											
	Use these codes for single metal inlay/onlay restorations. See the Fixed Prosthodontic Service section for metal inlay/only bridge retainers. Metal components include structures manufactured by means of conventional casting and/or electroforming. The benefits provided by some medical schemes for metal inlays on anterior teeth (incisors and canines) may be subject to pre-authorisation.										06.03
8361	Inlay - metal - one surface	04.00	193.10 (169.40)				380.90 (334.10)		T	+L	A
8362	Inlay/onlay - metal - two surfaces	04.00	282.40 (247.70)				552.30 (484.50)		T	+L	A
8363	Inlay/onlay - metal - three surfaces	04.00	470.90 (413.10)				856.50 (751.30)		T	+L	A
8364	Inlay/onlay - metal - four or more surfaces	04.00	569.40 (499.50)				856.50 (751.30)		T	+L	A
Porcelain/Ceramic Inlays/Onlays											
	Use these codes for single porcelain/ceramic inlay/onlay restorations. See the Fixed Prosthodontic Service section for porcelain/ceramic inlay/only bridge retainers. Porcelain/ceramic inlays/onlays include all indirect ceramic, porcelain and polymer-reinforced porcelain type inlays/onlays. Fees for the application of a rubber dam (8304) may be levied in addition to these codes. TO BE CONFIRMED: When computer generated (CAD-CAM) ceramic restorations are fabricated by the dental practitioner, laboratory costs do not apply. Report codes 8570 (Fabrication of computer generated ceramic restoration) and 8560 for the cost of the ceramic block in addition to the restoration.										06.03
8371	Inlay - porcelain - one surface	05.02	232.70 (204.10)				460.10 (403.60)		T	(+L)	A
8372	Inlay/onlay - porcelain - two surfaces	05.02	343.60 (301.40)				662.60 (581.20)		T	(+L)	A
8373	Inlay/onlay - porcelain - three surfaces	05.02	566.30 (496.80)				1029.50 (903.10)		T	(+L)	A
8374	Inlay/onlay - porcelain - four or more surfaces	05.02	685.90 (601.70)				1029.50 (903.10)		T	(+L)	A
8560	Cost of ceramic block	06.03	-				-		T		A
	Applicable to computer generated prosthesis only. See Rule 002 and Modifier 8025.										
8570	Fabrication of computer generated ceramic restoration	06.03							A		
	This procedure involves the fabrication of a computer generated (CAD-CAM) ceramic restoration by the dental practitioner. Report code 8560 for the cost of the ceramic block in addition to this procedure.										

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Resin-based Inlays/Onlays												
	Resin based inlays/onlays usually utilise the indirect technique. Fees for the application of a rubber dam (8304) may be levied in addition to these codes. When the direct technique is used, laboratory costs do not apply. An additional fee may be levied by reporting Modifier 8023 in addition to these codes.											06.03
8381	Inlay - resin - one surface	05.02	232.70 (204.10)				460.10 (403.60)		T	(+L)	A	
8382	Inlay/onlay - resin - two surfaces	05.02	343.60 (301.40)				662.60 (581.20)		T	(+L)	A	
8383	Inlay/onlay - resin - three surfaces	05.02	566.30 (496.80)				1029.50 (903.10)		T	(+L)	A	
8384	Inlay/onlay - resin - four or more surfaces	05.02	685.90 (601.70)				1029.50 (903.10)		T	(+L)	A	
CROWNS – SINGLE RESTORATIONS												
	Use these codes for single crown restorations. See the Fixed Prosthodontic Service section for crown bridge retainers and the Implant Services section for crowns on osseo-integrated implants. Porcelain/ceramic crowns include all ceramic, porcelain and porcelain fused to metal crowns. Resin crowns and resin metal crowns include all reinforced heat and/or pressure-cured resin materials. Metal components include structures manufactured by means of conventional casting and/or electroforming. Temporary and/or intermediate crowns, the removal thereof (provisional crowns included) and cementing of the permanent restorations are included as part of the restorations. TO BE CONFIRMED: When computer generated (CAD-CAM) ceramic restorations are fabricated by the dental practitioner, laboratory costs do not apply. Report codes 8570 (Fabrication of computer generated ceramic restoration) and 8560 for the cost of the ceramic block in addition to the restoration.											06.03
8401	Crown - full cast metal	04.00	726.10 (636.90)				1069.00 (937.70)		T	+L	A	
8403	Crown - 3/4 cast metal	04.00	726.10 (636.90)				1069.00 (937.70)		T	+L	A	
8404	Crown - 3/4 porcelain/ceramic	05.02	685.80 (601.60)				1029.50 (903.10)		T	+L	A	
8405	Crown - resin laboratory	06.03	685.80 (601.60)				1029.50 (903.10)		T	+L	A	
	Refers to all resin-based crowns that are indirectly fabricated. All fiber, porcelain or ceramic reinforced polymer materials/systems are considered resin-based crowns. Targis®/Vectris® crowns should be reported as resin crowns.											
8407	Crown - resin with metal	04.00	726.10 (636.90)				1069.00 (937.70)		T	+L	A	
8409	Crown - porcelain/ceramic	04.00	726.10 (636.90)				1069.00 (937.70)		T	+L	A	
8411	Crown - porcelain with metal	04.00	726.10 (636.90)				1069.00 (937.70)		T	+L	A	
8410	Provisional crown	06.03	141.10 (123.80)			141.10 (123.80)	211.80 (185.80)		T	(+L)	A	
	The intended use of a provisional crown is to allow adequate time (of at least six weeks duration) for healing or completion of other procedures during restorative treatment and should not to be used as a temporary prosthesis. Comment: Code 8410 excludes provisional pontics (code 8425) and provisional crown retainers (code 8447), which are listed in the Fixed Prosthodontics Section.											
VENEERS												
8355	Veneer - resin (chair-side)	06.03	220.40 (193.30)				220.40 (193.30)		T			B
	Involves direct layering of material over tooth. No laboratory processing.											

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8552	Veneer - porcelain (laboratory)	06.03	487.70 (427.80)				731.50 (641.70)		T	+L	A
	Involves an impression being taken and laboratory processing. Porcelain/ceramic veneers presently include all ceramic, porcelain, and polymer-reinforced porcelain veneers.										
8554	Veneer - resin (laboratory)	06.03	487.70 (427.80)				731.50 (641.70)		T	+L	A
	Involves an impression being taken and laboratory processing.										
TEMPORARY RESTORATIONS											
8137	Emergency crown (chair-side)	06.03	218.00 (191.20)				218.00 (191.20)		T	(+L)	A
	A temporary crown, usually made of resin and in the surgery, which is fitted over a damaged tooth for the immediate protection in tooth injury. Includes emergency crowns manufactured for the replacement of previously fitted, lost or damaged permanent crowns. Comment: This code should not be used as an interim restoration during restorative treatment and should not be reported on the same day on which an impression is taken to replace a previously fitted lost or damaged permanent crown.										
8357	Prefabricated metal crown	06.03	129.60 (113.70)				129.60 (113.70)		T		B
	Includes all preformed metal crowns e.g. stainless steel, nickel-chrome and gold anodised crowns, with or without resin window.										
8375	Prefabricated resin crown	06.03	129.60 (113.70)				129.60 (113.70)		T		B
	Includes all preformed non-metal, non-strip- off crown forms e.g., resin and polycarbonate crowns.										
OTHER RESTORATIVE PROCEDURES											
Pin Retention and Cores											
8345	Prefabricated post retention, per post (in addition to restoration)	06.03	124.90 (109.60)						T		B
	Should not be used with codes 8398 or 8376 (Core build-ups) Remuneration excludes cost of posts – See code 8379										
8347	Pin retention - first pin (in addition to restoration)	06.03	62.80 (55.10)						T		B
	Should not be used with codes 8398 or 8376 (Core build-ups).										
8348	Pin retention - each additional pin (in addition to restoration)	06.03	58.20 (51.10)						T		B
	Should not be used with codes 8398 or 8376 (Core build-ups). Limitation: A maximum of two additional pins may be levied.										
8366	Pin retention as part of cast restoration (any number of pins)	05.02	93.90 (82.40)				127.20 (111.60)		T	+L	A
8376	Core build-up with prefabricated posts	06.03	346.00 (303.50)				346.00 (303.50)		T		B
	The direct build-up of a mutilated crown around a prefabricated post to provide a rigid base for retention of a crown restoration. This procedure includes posts and core material. Remuneration excludes cost of posts – See code 8379.										
8379	Cost of prefabricated posts	06.03	-				-		T		A
	Applicable to pre-fabricated noble metal, ceramic, iridium and titanium posts – see code 8345 and 8376. Comment: See Rule 002 and Modifier 8025 for direct material costs.										

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8391	Cast core with single post	06.03	145.90 (128.00)						T	+L	A
	Report in addition to crown.										
8392	Cast post (each additional)	06.03	86.90 (76.20)						T	+L	A
	To be used with 8391 for each additional cast posts on the same tooth.										
8397	Cast core with pins (any number of pins)	06.03	232.70 (204.10)				302.60 (265.40)		T	+L	A
	The cast core with pins is intended to be used on grossly broken down vital teeth. Report in addition to crown.										
8398	Core build-up with or without pins	06.03	282.40 (247.70)				282.40 (247.70)		T		B
	The direct build-up of a mutilated crown to provide a rigid base for retention of a crown restoration irrespective of the number of pins used. This code should not be reported when the procedure only involves a filler to eliminate any undercut, concave irregularity in the preparation, etc.										
8581	Cast core with single post	06.03					215.60 (189.10)		T	+L	A
	See also GDP code 8391										
8582	Cast core with double post	06.03					307.20 (269.50)		T	+L	A
	See also GDP code 8392										
8583	Cast core with triple post	06.03					380.90 (334.10)		T	+L	A
	See also GDP code 8392										
Unclassified Restorative Procedures											
8133	Recement inlay, onlay, crown or veneer	06.03	63.60 (55.80)				80.70 (70.80)		T	+L	B
	Use to report the recementation of a permanent single inlay, onlay, crown or veneer. See code 8514 in the Fixed Prosthodontic Section for the recementation of a bridge retainer. Comment: This code may not be used for the recementation of temporary or provisional restorations, which is included as part of the restoration.										
8135	Remove inlay, onlay or crown	06.03	126.50 (111.00)				126.50 (111.00)		T	+L	A
	This procedure involves the removal of a permanent inlay, onlay or crown. Report code 8516 for the removal of a permanent bridge retainer. Comment: This code may not be used for the removal of temporary or provisional restorations, which is included as part of the restoration.										
8138	Remove retention post (prefabricated or cast)	06.03	83.00 (72.80)						T		B
	This procedure involves the removal of an intact prefabricated and/or cast posts intended for retention purposes. Report per post. See code 8330 in the "Endodontic Section" for the removal of endodontic posts or instruments.										
8146	Resin bonding for restorations	06.03							T		A
	Applicable to any metal restorations, crowns or conventional bridges, per abutment except Maryland type bridges. Limitation: Benefits by arrangement.										
8157	Re-burnishing and polishing of restorations - complete dentition	06.03	63.60 (55.80)								B

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	Not applicable to restorations recently done.										
8349	Carve restoration to accommodate existing removable prosthesis	04.00	25.60 (22.50)						T		B
8413	Repair crown (permanent or provisional)	06.03	141.10 (123.80)				141.10 (123.80)		T	+L	A
	This procedure involves the repair of a permanent crown (e.g. facing replacement). Excludes the removal (8153) and recementation (8133) of the crown. See code 8518 in the Fixed Prosthodontic Section for the repair of a bridge. This code may also be reported for the repair/replacement of a provisional crown (8410) after a period of two months. This code may not be used for the repair/replacement of a temporary restorations, which is included as part of the restoration.										
8414	Additional fee for provision of crown within an existing clasp or rest	04.00	41.90 (36.80)						T	+L	A
D. ENDODONTIC SERVICES											
	Services/procedures intended to treat diseases of the dental pulp and their sequelae.										06.03
PULP CAPPING											
	These codes should not be used as a base or liner under a restoration. Certain funders (medical aids) may restrict the placement of the final restoration during the same visit.										06.03
8301	Pulp cap - direct	06.03	84.50 (74.10)						T		B
	This procedure involves the covering of the exposed dental pulp with a protective material to stimulate repair of the injured pulpal tissue. Excludes the final restoration.										
8303	Pulp cap - indirect	06.03	84.50 (74.10)						T		B
	This procedure involves the covering of the nearly exposed pulp with a protective material to protect it from external irritants and to promote healing. Excludes the final restoration.										
PULPOTOMY											
8307	Pulp amputation (pulpotomy)	06.03	83.00 (72.80)						T		B
	This procedure involves the removal of a portion of the tooth's pulp and the placement of a medicament to fix or modify the superficial pulp tissue. Excludes the final restoration. This code should not be used as the first stage of root canal therapy and may not be reported with other root canal therapy codes on the same tooth. Report code 8304 (application of a rubber dam) in addition to this code.										
8132	Pulp removal (pulpectomy)	06.03	104.00 (91.20)						T		B
	This procedure involves the removal of the complete pulp from the pulp chamber and root canal(s) for the relief of acute pain prior to root canal therapy. The code is intended to be used for the emergency treatment of acute pain and should not be reported as the first stage of scheduled endodontic treatment. The practitioner reappoints the patient for complete root canal therapy at a later date. Report code 8304 (application of a rubber dam) in addition to this code.										
ENDODONTIC THERAPY											
	Includes endodontic therapy on primary teeth. Does not include diagnostic evaluation and necessary radiographs/ diagnostic images. Limitation: Intra-operative radiographs/ diagnostic images are limited to three on a single canal tooth and five on a multi-canal tooth for each completed endodontic therapy. Report code 8304 (application of a rubber dam) in addition to these codes.										06.03
Preparatory Visits											
8332	Root canal preparatory visit - single canal tooth	06.03	63.60 (55.80)						T		B
	Limitation: A maximum of four visits per tooth may be charged.										
8333	Root canal preparatory visit - multi canal tooth	06.03	89.20 (78.20)						T		B

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	Limitation: A maximum of four visits per tooth may be charged.										
Obtuation of Canals											
	Codes 8328, 8335, 8336 and 8337 (obturation of root canals at a subsequent visit) are intended to be used in conjunction with codes 8332, 8333 and 8334 (endodontic preparatory visits and re-preparation of previously obturated canal).									06.03	
8335	Root canal obturation - anteriors and premolars - first canal	04.00	288.60 (253.20)						T		B
8328	Root canal obturation - anteriors and premolars - each additional canal	04.00	118.00 (103.50)						T		B
8336	Root canal obturation - posteriors - first canal	04.00	397.20 (348.40)						T		B
8337	Root canal obturation - posteriors - each additional canal	04.00	118.00 (103.50)						T		B
Complete Therapy											
	Codes 8329, 8338, 8339 and 8340 (endodontic treatment completed at a single visit) may not be used with codes 8332, 8333 and 8334 (endodontic preparatory visits and re-preparation of previously obturated canal).									06.03	
8338	Root canal therapy - anteriors and premolars - first canal	04.00	441.40 (387.20)						T		B
8329	Root canal therapy - anteriors and premolars - each additional canal	04.00	147.40 (129.30)						T		B
8339	Root canal therapy - posteriors - first canal	04.00	606.60 (532.10)						T		B
8340	Root canal therapy - posteriors - each additional canal	04.00	147.40 (129.30)						T		B
8631	Root canal therapy - first canal	06.03					749.40 (657.40)		T		B
	Procedure codes 8631, 8633 and 8334 include all X-rays and repeat visits.										
8633	Root canal therapy - each additional canal	06.03					188.50 (165.40)		T		B
	Procedure codes 8631, 8633 and 8334 include all X-rays and repeat visits.										
ENDODONTIC RETREATMENT											
8334	Re-preparation of previously obturated root canal	06.03	93.90 (82.40)				113.20 (99.30)		T		B
	This procedure includes the removal of old root canal filling material and the procedures necessary to prepare the canals to place the canal filling. Report 8334 per canal. See codes 8328, 8335, 8336 and 8337 for the obturation of root canals. This procedure excludes the removal of retentions posts (code 8138) and/or endodontic posts (code 8330). Report code 8304 (application of a rubber dam) in addition to this code. Note (Applicable to prosthodontist only): Procedure codes 8631, 8633 and 8334 include all X-rays and repeat visits.										
APEXIFICATION/RECALCIFICATION PROCEDURES											
8635	Apexification/recalcification – per visit	06.03	84.50 (74.10)				124.90 (109.60)		T		S

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	Apexification is the process of induced root development or apical closure of the root by hard tissue deposition. This code should also be used to report the repair of perforations and root resorption. Exclude the necessary radiographs. The first visit involves the opening of the tooth, pulpectomy, preparation of canal spaces, and the first placement of medication. This is followed by several visits to replace the intra-canal medication. The final visit includes the removal of the intra-canal medication and procedures necessary to place final root canal filling material. Code 8635 may not be reported with other root canal therapy codes on the same tooth. Report code 8304 (application of a rubber dam) in addition to this code.									
PERIRADICULAR PROCEDURES										
9015	Apicectomy - anteriors (including retrograde filling)	06.03	313.40 (274.90)	415.80 (364.70)		415.80 (364.70)	415.80 (364.70)		T	S
	Note applicable to periodontists only (according to SADA's Dental Coding): When Code 9015 is part of a flap operation that requires an apicectomy, Modifier 8006 applies.									
9016	Apicectomy - posteriors (including retrograde filling)	06.03	552.90 (485.00)	829.30 (727.50)		829.30 (727.50)	829.30 (727.50)		T	S
	Note applicable to periodontists only (according to SADA's Dental Coding): When Code 9016 is part of a flap operation that requires an apicectomy, Modifier 8006 applies.									
OTHER ENDODONTIC PROCEDURES										
8330	Removal of root canal obstruction	06.03	83.00 (72.80)						T	B
	This procedure involves the treatment of a non-negotiable root canal blocked by foreign bodies (e.g., removal and/or bypassing of a fractured instrument) or calcification of 50% or more of a root to achieve an apical seal and forego surgical treatment – Report per canal. See code 8138 (Post removal) in the Restorative Section for the removal of retention posts. This code may be submitted by the servicing provider and on the same day as a root canal therapy if the obstruction is not iatrogenic by that provider.									
8136	Access through a prosthetic crown or inlay to facilitate root canal treatment	04.00	56.60 (49.60)						T	B
8640	Removal of fractured post or instrument from root canal	06.03					220.40 (193.30)		T	B
	See also GDP Code 8330.									
8765	Hemisection of a tooth, resection of a root or tunnel preparation (isolated procedure)	06.03	277.20 (243.20)			415.80 (364.70)	415.80 (364.70)		T	A
	Includes separation of a multirooted tooth into separate sections containing the root and overlying portion of the crown. It may also include the removal of one or more of those sections.									
E. PERIODONTIC SERVICES										
	The branch of dentistry used to treat and prevent disease affecting the gingivae, ligaments and bone that supports the teeth.									06.03
SURGICAL SERVICES										
	Surgical services includes usual postoperative care.									06.03
8741	Gingivectomy/gingivoplasty - four or more teeth per quadrant	06.03	332.10 (291.30)			455.40 (399.50)			Q	A
	A gingivectomy involves the surgical excision of unsupported gingival tissue to the level where it is attached, creating a new gingival margin apical in position of the old. A gingivoplasty involves the surgical contouring of the gingival tissues to secure the physiological architectural form necessary for the maintenance of tissue health and integrity. Edentulous areas are not counted as teeth. When this periodontal procedure extends over the midline, report a combination of procedure codes 8741 and 8743, as appropriate.									

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8743	Gingivectomy or gingivoplasty - one to three teeth per quadrant	06.03	265.30 (232.70)			361.50 (317.10)			Q		A
	See code 8741 for descriptor										
8749	Flap procedure, root planing and one to three surgical services - per quadrant	06.03	689.40 (604.70)			1034.10 (907.10)			Q		A
	Flap operation with root planing and curettage and which may include not more than 3 of the following: bone contouring, chemical treatment of root surfaces, root resection, tooth hemisection, a mucogingival procedure, wedge resection, clinical crown lengthening, per quadrant. NOTES:1. Each root resection, tooth hemisection, muco-gingival procedure, wedge resection and clinical crown lengthening shall be deemed to be one procedure. 2. Where a bone regeneration/repair procedure is included within a flap operation, Item 8766 shall apply in addition to the Item for the flap operation.3. Where an apicectomy is included within a flap operation, either Code 9015 or Code 9016 with Modifier 8006 shall apply in addition to the item for the flap operation.										
8751	Flap procedure, root planing and one to three surgical services - per sextant	06.03	571.00 (500.90)			856.50 (751.30)			S		A
	See code 8749, per sextant.										
8753	Flap procedure, root planing and four or more surgical services - per quadrant	06.03	854.50 (749.60)			1281.70 (1124.30)			Q		A
	Flap operation with root planing and curettage and will include more than 3 of the following: bone contouring, chemical treatment of root surfaces, root resection, tooth hemisection, a mucogingival procedure, wedge resection, clinical crown lengthening, per quadrant. NOTES:1. Each root resection, tooth hemisection, muco-gingival procedure, wedge resection and clinical crown lengthening shall be deemed to be one procedure. 2. Where a bone regeneration/repair procedure is included within a flap operation, Item 8766 shall apply in addition to the Item for the flap operation.3. Where an apicectomy is included within a flap operation, either Code 9015 or Code 9016 with Modifier 8006 shall apply in addition to the item for the flap operation.										
8755	Flap procedure, root planing and four or more surgical services - per sextant	06.03	692.50 (607.50)			1038.80 (911.20)			S		A
	See code 8753, per sextant.										
8756	Clinical crown lengthening (isolated procedure)	06.03	419.90 (368.30)			629.90 (552.50)			T		A
	A surgical procedure designed to increase the amount of tooth structure projecting into the mouth to facilitate a reconstructive or operative procedure. The procedure involves the reflection of a flap and the removal of marginal bone and gingival tissues.										
8759	Pedicle flapped graft (isolated procedure)	06.03	315.50 (276.80)			473.20 (415.10)			M		A
	E.g. lateral sliding double papilla, rotated and similar.										
8761	Masticatory mucosal autograft - one to four teeth (isolated procedure)	05.02	342.90 (300.80)	514.40 (451.20)		514.40 (451.20)			M	+L	A
8762	Masticatory mucosal autograft - four or more teeth (isolated procedure)	05.02	515.10 (451.80)	772.70 (677.80)		772.70 (677.80)			M	+L	A
8763	Wedge resection (isolated procedure)	06.03	201.70 (176.90)			302.60 (265.40)			Q		A

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	A surgical procedure that involves the removal of a wedge of tissue. This is normally done in an edentulous area, distal of the last molar of the maxilla or mandible, to result in minimal probing depth of the adjacent tooth. Do not use for a biopsy.										
8766	Bone regeneration/repair procedure - as part of a flap operation	06.03	165.00 (144.70)			247.50 (217.10)					A
	See code 8749, 8751, 8753 and 8755, per procedure. Excluding cost of regenerative material - See code 8770										
8767	Bone regeneration/repair procedure - at a single site	06.03	427.70 (375.20)	641.60 (562.80)		641.60 (562.80)					A
	Excluding cost of regenerative material - See code 8770										
8769	Membrane removal (used for guided tissue regeneration)	06.03	201.70 (176.90)	302.60 (265.40)		302.60 (265.40)					A
	Note: Maxillo-facial Surgeons may, according to SADA's Dental Coding, use codes 8761, 8767 and 8769 only as part of implant surgery.										
8770	Cost of bone regenerative/repair material	06.03	-	-		-					A
	See Rule 002 and Modifier 8025 for direct material costs										
8772	Submucosal connective tissue autograft (isolated procedure)	05.02	346.50 (303.90)	519.80 (456.00)		519.80 (456.00)					A
8995	Gingivectomy - per jaw	06.03	491.90 (431.50)	737.80 (647.20)					M	+L	S
	See also codes 8741 and 8743.										
NON-SURGICAL PERIODONTAL SERVICES											
8723	Provisional splinting - extracoronal (wire) - per sextant	05.02	118.00 (103.50)			176.90 (155.20)	176.90 (155.20)		M	+L	A
8725	Provisional splinting - extracoronal (wire plus resin) - per sextant	05.02	171.20 (150.20)			256.80 (225.30)	256.80 (225.30)		M	+L	A
8727	Provisional splinting - intracoronal - per tooth	06.03	53.70 (47.10)			80.70 (70.80)	80.70 (70.80)		T	+L	A
	Include intracoronal wire or pins or cast bar, plus amalgam or resin, per dental unit included in the splint										
8737	Root planing - four or more teeth per quadrant	06.03	254.50 (223.20)			345.20 (302.80)			Q		A
	A procedure that smooths the surface of a root by removing abnormal toxic cementum or dentin that is rough, contaminated, or permeated with calculus. May include a subgingival curettage (controversial procedure). When this periodontal procedure extends over the midline, report a combination of procedure codes 8737 and 8739, as appropriate. Other separate procedures including, but not limited to a comprehensive oral evaluation (8102) or periodontal screening (8176) and diagnostic radiographs (8107/8108), are a prerequisite to reporting Code 8737. Should not be reported concurrent with Codes 8159, 8160, 8179 or 8180.										
8739	Root planing - one to three teeth per quadrant	06.03	202.50 (177.60)			275.40 (241.60)			Q		A
	See code 8737.										
8773	Cost of intrapocket chemotherapeutic agent	06.03	-			-					
	Used to report intrapocket chemotherapeutic agents provided by the practitioner. See Rule 002 and Modifier 8025 for direct material costs.										

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OTHER PERIODONTAL SERVICES												
8768	Unlisted periodontal procedure	04.00	201.70 (176.90)				302.60 (265.40)			T		A
8787	Unlisted oral medicine procedure	04.00	72.40 (63.50)				108.60 (95.30)					S
F.	REMOVABLE PROSTHODONTICS											
	The branch of prosthodontics concerned with the replacement of teeth by artificial substitutes that is readily removable. Removable prosthodontic services include routine post-operative care.											06.03
COMPLETE DENTURES												
8231	Complete dentures - maxillary and mandibular	06.03	1025.60 (899.60)				2141.20 (1878.20)			M	+L	B
	Inclusive of soft bases or metal bases, where applicable.											
8232	Complete denture - maxillary or mandibular	06.03	632.30 (554.60)				1498.10 (1314.10)			M	+L	B
	Inclusive of soft bases or metal bases, where applicable.											
8244	Immediate denture - maxillary	06.03	632.30 (554.60)				948.40 (831.90)				+L	
	A removable complete denture constructed for placement immediately after removal of the remaining natural teeth. This procedure includes limited follow-up care only and excludes subsequent rebasing/relining procedure(s) and/or the replacement with new complete denture. See interim prosthesis for immediate and/or provisional partial dentures.											
8245	Immediate denture - mandibular	06.03	632.30 (554.60)				948.40 (831.90)				+L	
	See 8244 descriptor.											
8643	Complete dentures - maxillary and mandibular (with complications)	04.00					2778.90 (2437.60)				+L	B
8645	Complete dentures - maxillary and mandibular (with major complications)	04.00					3418.20 (2998.40)				+L	B
8649	Complete denture - maxillary or mandibular (with complications)	05.02					1709.80 (1499.80)			M	+L	B
8651	Complete denture - maxillary or mandibular (with major complications)	05.02					1923.20 (1687.00)			M	+L	B
PARTIAL DENTURES												
8233	Partial denture - resin base - one tooth	05.02	294.00 (257.90)							M	+L	B
8234	Partial denture - resin base - two teeth	05.02	294.00 (257.90)							M	+L	B
8235	Partial denture - resin base - three teeth	05.02	439.90 (385.90)							M	+L	B
8236	Partial denture - resin base - four teeth	05.02	439.90 (385.90)							M	+L	B
8237	Partial denture - resin base - five teeth	05.02	439.90 (385.90)							M	+L	B
8238	Partial denture - resin base - six teeth	05.02	583.40 (511.80)							M	+L	B

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8239	Partial denture - resin base - seven teeth	05.02	583.40 (511.80)						M	+L	B
8240	Partial denture - resin base - eight teeth	05.02	583.40 (511.80)						M	+L	B
8241	Partial denture - resin base - nine or more teeth	05.02	583.40 (511.80)						M	+L	B
8281	Partial denture - cast metal framework only	06.03	685.90 (601.70)						M	+L	A
	The procedure refers to the metal framework only, and includes all clasps, rests and bars (i.e., 8251, 8253, 8255 and 8257). See codes 8233 to 8241 for the resin denture base required concurrently with 8281.										
8671	Partial denture - cast metal framework with resin denture base	06.03					1709.80 (1499.80)		M	+L	A
	See also GDP Code 8281.										
ADJUSTMENTS TO DENTURES											
8275	Adjust complete or partial denture	06.03	46.60 (40.90)				46.60 (40.90)				B
	After six months or for patient of another practitioner.										
8662	Adjust complete or partial dentures (remounting)	04.00	164.50 (144.30)				246.80 (216.50)			+L	B
REPAIRS TO DENTURES											
	Professional fees should not be levied for the repair of dentures/intra-oral appliances if the practitioner did not examine the patient. Laboratory costs, however, may be recovered.										06.03
8269	Repair denture or other intra-oral appliance	06.03	80.70 (70.80)				86.90 (76.20)		M	+L	B
	See code 8273 (Impression to repair/modify a denture)										
8270	Add clasp to existing partial denture	06.03	58.20 (51.10)						M	+L	B
	One or more clasps. Code 8270 may be reported in addition to code 8269. See code 8273 (Impression to repair/modify a denture).										
8271	Add tooth to existing partial denture	06.03	58.20 (51.10)						M	+L	B
	One or more teeth. Code 8271 may be reported in addition to code 8269. See code 8273 (Impression to repair/modify a denture).										
8273	Impression to repair or modify a denture or other intra-oral appliance	06.03	46.60 (40.90)				46.60 (40.90)			+L	B
	May be reported in addition to the appropriate code in this subsection when an impression is required. Includes any number of impressions.										
DENTURE REBASE PROCEDURES											
	Rebase – The partial or complete removal and replacement of the denture base.										06.03
8259	Rebase complete or partial denture (laboratory)	05.02	239.70 (210.30)				346.00 (303.50)		M	+L	B
8261	Remodel complete or partial denture	05.02	384.80 (337.50)						M	+L	B
DENTURE RELINE PROCEDURES											
	Reline - The addition of material to the fitting surface of a denture base.										06.03
8263	Reline complete or partial denture (chair-side)	05.02	152.10 (133.40)				190.00 (166.70)		M		B

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8267	Reline complete or partial denture (laboratory)	06.03	349.90 (306.90)				349.90 (306.90)		M	+L	B
	This procedure is intended to be used for the relining of existing dentures and should not be reported concurrently with codes 8231 to 8241. See code 8243 (soft base to new denture).										
INTERIM DENTURES											
	Also known as provisional, temporary, or transitional dentures. Provisional dentures are used for a limited period of time for reasons of aesthetics, function or occlusal support, after which it is replaced by a more definitive prosthesis.										06.03
8658	Interim complete denture	06.03	632.20 (554.60)				948.40 (831.90)		M	+L	B
	See code 8659 for descriptor.										
8659	Interim partial denture	06.03	505.80 (443.70)				758.70 (665.50)		M	+L	B
	May be used to submit the use of a flipper (stayplate). A stayplate is an acrylic partial, with or without wire clasps, that replaces one or more teeth usually temporary in nature. Includes any necessary clasps and rests. This code should not be used in lieu of space maintainers.										
8661	Diagnostic dentures (including tissue conditioning)	06.03					1709.80 (1499.80)			+L	A
	See also codes 8658, 8659 and 8265.										
OTHER REMOVABLE PROSTHETIC PROCEDURES											
8251	Clasp or rest - cast gold	06.03	58.20 (51.10)							+L	A
	Codes 8251, 8253, 8255 and 8257 may not be levied concurrently with codes 8169 (occlusal orthotic device), 8175 (space maintainer), 8269 (repair of denture) or 8281 (metal framework).										
8253	Clasp or rest - wrought gold	06.03	58.20 (51.10)							+L	B
	See code 8251 descriptor.										
8255	Clasp or rest - stainless steel	06.03	61.20 (53.70)							+L	B
	See code 8251 descriptor.										
8257	Bar - lingual or palatal	06.03	72.20 (63.30)						M	+L	B
	See code 8251 descriptor.										
8265	Tissues conditioning per arch (including soft self-cure reline)	05.02	99.30 (87.10)				127.20 (111.60)		M		B
8277	Inlay in denture	06.03								+L	A
	Limitation: Benefits by arrangement.										
8597	Locks and milled rests	04.00	57.90 (50.80)				86.90 (76.20)		T	+L	A
8599	Precision attachment (removable denture)	06.03	141.10 (123.80)				211.80 (185.80)		M	+L	A
	Each set of male and female components should be reported as one precision attachment. Includes semi-precision attachments.										
8652	Overdenture - complete	06.04	1139.90 (999.90)				1709.80 (1499.80)		M	+L	B
	Other separate procedures may be required concurrent to 8652.										
8653	Overdenture - partial	06.04	911.90 (799.90)				1367.90 (1199.90)		M	+L	B

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	Other separate procedures may be required concurrent to 8653.											
8657	Replacement of precision attachment	06.03	80.70 (70.80)				86.90 (76.20)		M	+L	A	
	This procedure involves the replacement of the replaceable part (male for female component) of a semi-precision or precision attachment. Report per denture.											
8663	Metal base to complete denture	06.03	343.40 (301.20)				515.10 (451.80)		M	+L	A	
	E.g. chrome cobalt, gold, etc.											
8664	Remount crown or bridge for prosthetics	04.00	164.50 (144.30)				257.80 (226.10)				A	
8667	Soft base to denture (heat cured)	05.02	343.40 (301.20)				515.10 (451.80)		M	+L	B	
8672	Altered cast technique (in addition to partial denture)	05.02	44.00 (38.60)				66.00 (57.90)		M	+L	B	
8674	Additive partial denture	05.02	517.20 (453.70)				775.80 (680.50)		M	+L	B	
G.	MAXILLO-FACIAL PROSTHETICS											
	The branch of prosthodontics concerned with the restoration of stomatognathic and associated facial structures that have been affected by disease, injury, surgery or congenital defect. Where "+D" appears the practitioner will charge the relevant fee/benefit for the denture in the Schedule plus the fee/benefit indicated											06.03
	MAXILLIARY PROSTHESIS											
9101	Obturator prosthesis, surgical - modified denture	04.00	84.90 (74.50)				127.20 (111.60)			+L		
9102	Obturator prosthesis, surgical - continuous base	04.00	230.10 (201.80)				345.20 (302.80)			+L		
9103	Obturator prosthesis, surgical - split base	04.00	342.90 (300.80)				514.40 (451.20)			+L		
9104	Obturator prosthesis, interim - on existing denture	04.00	517.20 (453.70)				775.80 (680.50)			+L		
9105	Obturator prosthesis, interim - on new denture	04.00	1597.20 (1401.10)				2395.70 (2101.50)			+L		
9106	Obturator prosthesis, definitive - open/hollow box	04.00	517.20 (453.70)				775.80 (680.50)			+D		
9107	Obturator prosthesis, definitive - silicone glove	04.00	998.70 (876.10)				1498.10 (1314.10)			+D		
	MANDIBULAR RESECTION PROSTHESES											
9108	Mandibular resection prosthesis w/ guide flange	04.00	1226.80 (1076.10)				1840.20 (1614.20)			+L		
9109	Mandibular resection prosthesis w/o guide flange	04.00	1139.90 (999.90)				1709.80 (1499.80)			+L		
9110	Mandibular resection prosthesis, palatal augmentation	04.00	230.10 (201.80)				345.20 (302.80)			+D		
	GLOSSAL RESECTION PROSTHESES											
9111	Glossal resection prosthesis - simple	04.00	479.90 (421.00)				720.00 (631.60)			+D		
9112	Glossal resection prosthesis - complex	04.00	719.00 (630.70)				1078.40 (946.00)			+D		

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RADIOTHERAPY APPLIANCES											
9113	Radiation carrier - simple	04.00	517.20 (453.70)				775.80 (680.50)			+L	
9114	Radiation carrier - complex	04.00	1427.40 (1252.10)				2141.20 (1878.20)			+L	
9115	Radiation shield - simple	04.00	517.20 (453.70)				775.80 (680.50)			+L	
9116	Radiation shield - complex	04.00	1427.40 (1252.10)				2141.20 (1878.20)			+L	
9117	Radiation cone locator	04.00	517.20 (453.70)				775.80 (680.50)			+L	
CHEMOTHERAPY APPLIANCES											
9118	Chemotherapeutic agent carrier	04.00	517.20 (453.70)				775.80 (680.50)			+L	
CLEFT PALATE PROSTHESES											
8855	Consultation - cleft palate therapy (house or hospital)	04.00	118.00 (103.50)		176.90 (155.20)		176.90 (155.20)				S
8856	Consultation - cleft palate (subsequent)	04.00	57.90 (50.80)		86.90 (76.20)		86.90 (76.20)				S
8857	Consultation - cleft palate (maximum)	04.00	402.90 (353.40)		604.30 (530.10)		604.30 (530.10)				S
NEONATAL PROSTHESES											
9119	Feeding aid prosthesis, neonatal	04.00	457.80 (401.60)		686.60 (602.30)		686.60 (602.30)			+L	S
9120	Orthopaedic appliance, active presurgical - minor	04.00	457.80 (401.60)		686.60 (602.30)		686.60 (602.30)			+L	S
9121	Orthopaedic appliance, active presurgical - moderate	04.00	677.50 (594.30)		1016.30 (891.50)		1016.30 (891.50)			+L	S
9122	Orthopaedic appliance, active presurgical - severe	04.00	1139.90 (999.90)		1709.80 (1499.80)		1709.80 (1499.80)			+L	S
9123	Orthopaedic appliance, active presurgical - modification	04.00	57.90 (50.80)		86.90 (76.20)		86.90 (76.20)				S
INTERMEDIATE/DEFINITIVE PROSTHESES											
9125	Speech aid/obturator prosthesis - palatal alteration	04.00	230.60 (202.30)				346.00 (303.50)			+D	
9126	Speech aid/obturator prosthesis - velar alteration	04.00	517.20 (453.70)				775.80 (680.50)			+D	
9127	Speech aid/obturator prosthesis - pharyngeal alteration	04.00	1139.90 (999.90)				1709.80 (1499.80)			+D	
9128	Speech aid/obturator prosthesis - modification	04.00	57.90 (50.80)				86.90 (76.20)				
9129	Speech aid/obturator prosthesis - surgical	04.00	457.80 (401.60)				686.60 (602.30)			+L	
SPEECH APPLIANCES											
9130	Speech aid appliance - palatal lift	04.00	230.10 (201.80)				345.20 (302.80)			+D	
9131	Speech aid appliance - palatal stimulating	04.00	517.20 (453.70)				775.80 (680.50)			+D	

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9132	Speech aid appliance - bulb	04.00	1139.90 (999.90)				1709.80 (1499.80)		+D	
9133	Speech aid appliance - modification	04.00	57.90 (50.80)				86.90 (76.20)			
9134	Unspecified speech aid appliance	04.00	-				-		+L	
EXTRA-ORAL APPLIANCES										
9135	Auricular prosthesis - simple	04.00	1427.40 (1252.10)				2141.20 (1878.20)		+L	
9136	Auricular prosthesis - complex	04.00	1862.50 (1633.80)				2778.90 (2437.60)		+L	
9137	Nasal prosthesis - simple	04.00	1427.40 (1252.10)				2141.20 (1878.20)		+L	
9138	Nasal prosthesis - complex	04.00	1862.50 (1633.80)				2778.90 (2437.60)		+L	
9139	Ocular prosthesis - interim	04.00	517.20 (453.70)				775.80 (680.50)		+L	
9140	Ocular prosthesis - modified stock appliance	04.00	1283.10 (1125.50)				1924.70 (1688.30)		+L	
9141	Ocular prosthesis - custom appliance	04.00	1862.50 (1633.80)				2778.90 (2437.60)		+L	
9142	Orbital prosthesis - simple	04.00	1283.10 (1125.50)				1924.70 (1688.30)		+L	
9143	Orbital prosthesis - complex	04.00	1862.50 (1633.80)				2778.90 (2437.60)		+L	
9144	Facial prosthesis, combination - small	04.00								
9145	Facial prosthesis, combination - medium	04.00								
9146	Facial prosthesis, combination - large	04.00								
9147	Facial prosthesis, combination - complex	04.00								
9148	Unspecified body prosthesis - simple	04.00	1283.10 (1125.50)				1924.70 (1688.30)		+L	
9149	Unspecified body prosthesis - complex	04.00	1862.50 (1633.80)				2778.90 (2437.60)		+L	
9150	Facial prosthesis, surgical - simple	04.00	998.70 (876.10)				1498.10 (1314.10)		+L	
9151	Facial prosthesis, surgical - complex	04.00	1283.10 (1125.50)				1924.70 (1688.30)		+L	
9152	Extraoral appliance - additional prosthesis	04.00							+L	
9153	Extraoral appliance - replacement prosthesis	04.00							+L	
9155	Cranial prosthesis	04.00	517.20 (453.70)				775.80 (680.50)		+L	
CUSTOM IMPLANTS										
9156	Cranial implant prosthesis, custom made	04.00	624.30 (547.60)				936.40 (821.40)		+L	
9157	Facial implant prosthesis, custom made - simple	04.00	311.90 (273.60)				467.80 (410.40)		+L	
9158	Facial implant prosthesis, custom made - complex	04.00	624.30 (547.60)				936.40 (821.40)		+L	

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9159	Ocular implant prosthesis, custom made	04.00	311.90 (273.60)				467.80 (410.40)		+L	
9160	Body implant prosthesis - custom made	04.00	1388.20 (1217.70)				2082.30 (1826.60)		+L	
SURGICAL APPLIANCES										
9161	Surgical splint - simple	04.00	141.10 (123.80)				211.80 (185.80)		+L	
9162	Surgical splint - complex	04.00	517.20 (453.70)				775.80 (680.50)		+L	
9163	Surgical template - simple	04.00	141.10 (123.80)				211.80 (185.80)		+L	
9164	Surgical template - complex	04.00	517.20 (453.70)				775.80 (680.50)		+L	
9165	Surgical conformer - simple	04.00	141.10 (123.80)				211.80 (185.80)		+L	
9166	Surgical conformer - complex	04.00	517.20 (453.70)				775.80 (680.50)		+L	
TRISMUS APPLIANCES										
9167	Trismus appliance (simple)	04.00	57.90 (50.80)				86.90 (76.20)		+L	
9168	Trismus appliance (complex)	04.00	517.20 (453.70)				775.80 (680.50)		+L	
9169	Orthoses appliance	04.00	1139.90 (999.90)				1709.80 (1499.80)		+L	
9170	Facial palsy appliance	04.00	342.90 (300.80)				514.40 (451.20)		+D	
9171	Commissure splint	04.00	141.10 (123.80)				211.80 (185.80)		+L	
9172	Oral retractor, dynamic - per arm	04.00	141.10 (123.80)				211.80 (185.80)		+L	
9173	Hand splint	05.02							+L	
9174	Unspecified burn appliance	05.02	-				-		+L	
ATTENDANCE IN THEATRE										
9175	Theatre attendance (MaxFac prosthodont) /hour	04.00	190.80 (167.40)				286.30 (251.10)			
H.	IMPLANT SERVICES									
	Services/procedures concerned with the surgical insertion of materials and devices into, onto and about the jaws and oral cavity for purposes of oral maxillofacial or oral occlusal rehabilitation or cosmetic corrections.									06.03
SURGICAL IMPLANT PROCEDURES										
	The codes in this subsection are intended to report surgical procedures for the placement of implants to be used as prosthetic abutments. The surgical phase includes all procedures concerned with placing the implant into or onto the bone and preparation for the prosthetic phase.									06.03
9180	Surgical placement of sub-periosteal implant - preparatory stage	05.02	836.80 (734.00)	1255.30 (1101.10)					M	S
9181	Surgical placement of sub-periosteal implant - placement stage	05.02	836.80 (734.00)	1255.30 (1101.10)					M	+L S
9182	Surgical placement of endosteal implant plate	04.00	418.90 (367.50)	628.40 (551.20)		628.40 (551.20)			+L	S

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9183	Surgical placement of endosteal implant - first per jaw	06.03	589.60 (517.20)	801.40 (703.00)		801.40 (703.00)			T	+M	S
	Also known as a root form implant; endosseus or an osseo-integrated implant. This procedure involves (1) the surgical placement of a one stage and/or the first stage of a two stage surgery endosteal implant (fixture) and (2) the placement of a healing abutment/cap (when appropriate). Code 9183 includes the surgical placement of a one-piece endosteal implant (incorporating both the implant and integral fixed abutment) and should also be used to report the placement of an endosteal plate form implant. In such instances laboratory fees applies. See code 9190 hereunder for second stage surgery and code 9187 located in the "Other implant services" section to report the cost of the endosteal implant body.										
9184	Surgical placement of endosteal implant - second per jaw	05.02	441.40 (387.20)	601.20 (527.40)		601.20 (527.40)			T	+M	S
9185	Surgical placement of endosteal implant - third and subsequent per jaw	05.02	295.50 (259.20)	402.70 (353.20)		402.70 (353.20)			T	+M	S
9190	Surgical placement of abutment - first per jaw	06.03	218.70 (191.80)	296.30 (259.90)		296.30 (259.90)	296.30 (259.90)		T	+M	S
	This procedure involves the (1) surgical re-exposure (uncovery or second stage surgery) of that portion of the submerged endosteal implant that receives the attachment device, and (2) the connection of a healing abutment or temporary prosthesis. This is usually done after the implant has matured in the bone for several months. The purpose of a healing abutment or collar is to create an emergence profile in the gum tissues for the future implant crown. Some implants are designed to remain exposed in the mouth right after they are placed, abolishing an uncovery procedure. Report codes 8578 or 8579 (in the prosthodontists' code list) for the placement of the final abutment to permit fabrication of a dental prosthesis in addition to this code. See Codes 9188 and 9189 located in the "Other implant services" section to submit the cost of other implant components.										
9191	Surgical placement of abutment - second per jaw	05.02	164.40 (144.20)	222.70 (195.40)		222.70 (195.40)	222.70 (195.40)		T	+M	S
9192	Surgical placement of abutment - third and subsequent per jaw	05.02	110.10 (96.60)	149.80 (131.40)		149.80 (131.40)	149.80 (131.40)		T	+M	S
IMPLANT SUPPORTED PROSTHETICS											
	Services/procedures concerned with the construction and placement of fixed or removable prosthesis on any implant device. Prosthetic devices which are not listed in this subsection should be reported using existing fixed or removable prosthetic codes.										06.03
Abutments and Bars											
	These codes are intended to report the placement of final restorations and should not be used to report the placement of temporary/provisional components e.g., healing abutments/collars, temporary abutments, caps, cylinders, etc. Abutments as part of one-piece endosteal implants (incorporating both the implant and integral fixed abutment) are considered being part of the implant body and should not be reported in addition to the surgical placement of the implant. See Codes 9187 to 9189 located in the "Other implant services" section to submit the cost of implant components.										06.03
8584	Connector bar - implant supported	06.03	1139.90 (999.90)				1709.80 (1499.80)				
	Any bar that connects two or more implants to stabilise and anchor removable overdentures or fixed-detachable dentures. Report code 8578 (prefabricated abutment) for implant abutments separated from connecting bar (bar attachment) and code 8579 (custom abutment) for implant abutments as part of connecting bar in addition to this code. Includes attachments that are inserted in the denture for holding onto the bar. Use to report Preci Bar (Dolder) System attached to implant abutments. When the prefabricated metal Preci Bar is soldered to prefabricated abutments, report codes 8584 and 8578. When the plastic-wax Preci Bar is cast directly with the abutments, report codes 8584 and 8579.										

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8578	Prefabricated abutment	06.03	118.00 (103.50)				176.90 (155.20)				
	A prefabricated connection (abutment/precision attachment) to an implant that serves to support and/or retain any prosthesis or superstructure. Modification of a prefabricated abutment may be necessary. Code 8578 should not be used to report the placement of a healing abutment. See Code 9188 located in the "Other implant services" section to submit the cost of the prefabricated abutment.										
8579	Custom abutment	06.03	537.90 (471.80)				806.80 (707.70)				
	A tailor-made connection to an implant that serves to support and/or retain any prosthesis or superstructure. A custom made abutment is usually manufactured by a dental laboratory using a casting process.										
Removable Dentures											
8533	Implant supported removable complete overdenture	06.03	1139.90 (999.90)				1709.80 (1499.80)		M	+L	B
	A removable complete denture supported by dental implants to provide improved retention and stability. Overdentures are retained by abutments or bars (attachments) and can be removed by the patient at will. Currently includes acrylic and acrylic with metal base overdentures. A complete overdenture normally requires a minimum of two implants in the mandibula and four in the maxilla for effective support, retention and stability. Report the appropriate mesostructures in addition to this code.										
8534	Implant supported removable partial overdenture	06.03	911.90 (799.90)				1367.90 (1199.90)		M	+L	B
	See code 8533 for descriptor.										
Fixed-detachable Dentures											
8654	Implant supported fixed-detachable complete overdenture	06.03	1282.10 (1124.60)				1923.20 (1687.00)		M	+L	A
	A fixed complete denture supported by dental implants, or abutments placed on implants, to provide improved retention and stability; may be screw retained or cemented and cannot be removed by the patient; also known as a "hybrid prosthesis." Currently includes acrylic and acrylic with metal base fixed dentures. A fixed-detachable complete denture normally requires a minimum of five implants in the mandibula and six in the maxilla for effective support, retention and stability. When abutments are used, report code 8578 (prefabricated abutment) or code 8579 (custom abutment), as appropriate, in addition to this code. When the denture is supported directly on the implant body (no mesostructure or abutments are used), report code 8660 in addition to this code. When the design of the denture includes a metal base, report code 8663 (Metal base to complete denture) in addition to this code.										
8655	Implant supported fixed-detachable partial overdenture	06.03	1025.60 (899.60)				1317.90 (1156.10)		M	+L	A
	See code 8654 for descriptor.										
8660	Additional fee to implant supported fixed-detachable denture - per implant	06.03	176.90 (155.20)				176.90 (155.20)		T		A
	This code may be reported when an implant supported fixed denture is attached to an implant body (no mesostructure or abutments are used). Report per implant and identify the position (replaced tooth's number) of the implant(s). May only be used in conjunction with codes 8654 and 8655.										

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Crowns - Single Restorations												
8536	Crown - implant/abutment supported - porcelain/ceramic	06.03	942.60 (826.80)				1246.70 (1093.60)		T	+L	A	
	An artificial crown that is retained, supported, and stabilised by an implant or abutment on an implant; may be screw retained or cemented.											
8537	Crown - implant/abutment supported - porcelain with metal	05.02	942.60 (826.80)				1246.70 (1093.60)		T	+L	A	
8538	Crown - implant/abutment supported - cast metal	05.02	942.60 (826.80)				1246.70 (1093.60)		T	+L	A	
8592	Crown - implant/abutment supported	06.03					1246.70 (1093.60)		T	+L	A	
	An artificial crown that is retained, supported, and stabilised by an implant or an abutment on an implant; may be screw retained or cemented. See also codes 8536, 8537 and 8538.											
Bridge Retainers - Crowns												
8546	Crown retainer - implant/abutment supported - porcelain/ceramic	06.03	942.60 (826.80)				1246.70 (1093.60)		T	+L	A	
	A crown attaching a pontic(s) that is retained, supported, and stabilised by an implant or an abutment on an implant; may be screw retained or cemented.											
8547	Crown retainer - implant/abutment supported - porcelain with metal	05.02	942.60 (826.80)				1246.70 (1093.60)		T	+L	A	
8548	Crown retainer - implant/abutment supported - cast metal	05.02	942.60 (826.80)				1246.70 (1093.60)		T	+L	A	
OTHER IMPLANT SERVICES												
8590	Implant maintenance procedures - per implant	06.03	52.20 (45.80)				78.40 (68.80)		T			A
	This procedure involves the (1) removal of the superstructure(s), cleansing and reinsertion; (2) active deposit removal (debriding) of the implant; (3) examination of all aspects of the implant system (periimplant and prosthetic evaluation, including the occlusion and stability of the superstructure); and (4) patient home care reinforcement and modification. Report per implant and identify the position of the implant (replaced tooth's number) from which the superstructure has been removed. This procedure involves the maintenance of the implant and should not be reported when the superstructure is not removed. See code 8159 (prophylaxis – complete dentition) in the "Preventive Section". The procedure also involves patient home care reinforcement and modification, and codes 8151 (Oral hygiene instructions) or code 8153 (Oral hygiene instructions – each additional visit) should not be reported with this code. Radiographs, when indicated, may be reported in addition to this code (usually at each three months recall visit for the first year and annually thereafter).											
8594	Repair of implant supported prosthesis	06.03	57.90 (50.80)				86.90 (76.20)					
	Use this code to report the repair or replacement of any part of the implant supported prosthesis. See Codes 9189 to submit the cost of implant components (e.g. replacement clips).											
8595	Repair of implant abutment	06.03	57.90 (50.80)				86.90 (76.20)					
	Use this code to report the repair or replacement of any part of the implant abutment. See code 9188 to submit the cost of implant abutment and code 9189 to submit the cost of implant components (e.g. abutment screw).											
8600	Cost of implant components	06.03		-		-	-					S
	See Rule 002 and Modifier 8025 for direct material costs. See also codes 9187, 9188 and 9189.											
9187	Cost of endosteal implant body	06.03	-	-		-						S

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	Comment: See Rule 002 and Modifier 8025 for direct material costs. Report both code 9187 and Modifier 8025 per implant body.											
9188	Cost of prefabricated abutment	06.03	-									S
	Comment: See Rule 002 and Modifier 8025 for direct material costs. Report both code 9187 and Modifier 8025 per implant abutment.											
9189	Cost of other implant compnts	06.03	-									S
	Use this code to report all other implant components (implant fixtures and abutments excluded) which are a component part of the definite implant/implant prosthesis system. Comment: See Rule 002 and Modifier 8025 for direct material costs. Report both code 9189 and Modifier 8025 per component.											
9198	Surgical removal of implant	06.03	272.60 (239.10)	408.90 (358.70)			408.90 (358.70)				T	S
	This procedure involves the surgical removal of an implant, i.e. cutting of soft tissue and bone, removal of implant, and closure.											
I. FIXED PROSTHODONTICS												
	The branch of prosthodontics concerned with the replacement or restoration of teeth by artificial substitutes that are not readily removable. A prosthetic retainer (e.g., crown/inlay/onlay retainer) in this section is defined as a part of a bridge that attaches a pontic to the abutment tooth. A pontic is that part of a bridge which replaces a missing tooth or teeth. Each retainer and each pontic constitutes a unit in a bridge. Porcelain/ceramic retainers and pontics presently include all ceramic, porcelain and porcelain fused to metal retainers and pontics. Resin retainers and pontics and resin metal retainers and pontics include all reinforced heat and/or pressure-cured resin materials. Metal components include structures manufactured by means of conventional casting and/or electroforming.											06.03
PONTICS												
	Comment: Codes 8415, 8416, 8417 and 8418 include ovate pontic designs. The nomenclatures of the pontics have been revised to coincide with the nomenclature used for crowns, which improves accurate record keeping. A similar approach has been followed for crowns and inlays/onlays utilised as bridge retainers.											06.03
8415	Pontic - porcelain/ceramic	05.03	592.70 (519.90)								T +L	A
8416	Pontic - cast metal	05.03	470.90 (413.10)								T +L	A
8417	Pontic - resin with metal	05.03	592.70 (519.90)								T +L	A
8418	Pontic - porcelain fused to metal	05.03	592.70 (519.90)								T +L	A
8419	Provisional pontic	06.03	141.10 (123.80)				211.80 (185.80)				T (+L)	A
	The intended use of a provisional pontic is to allow adequate time (of at least six weeks duration) for healing or completion of other procedures during restorative treatment and should not to be used as a temporary prosthesis for routine bridges. Comment: Code 8410 (Provisional crown) previously included both provisional pontics (code 8419) and provisional crown retainers (code 8447)											
8611	Pontic - sanitary	06.03					646.20 (566.80)				T +L	A
	See GDP codes 8415 to 8418.											
8613	Pontic - posterior	06.03					790.60 (693.50)				T +L	A
	See GDP codes 8415 to 8418.											
8615	Pontic - anterior/premolar	06.03					854.20 (749.30)				T +L	A

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	See GDP codes 8415 to 8418.											
BRIDGE RETAINERS – INLAYS/ONLAYS												
	An inlay/onlay retainer for a bridge that gains retention, support and stability from a tooth. The cusp tip must be overlaid to be considered an onlay. See inlay/onlay restorations in the Restorative Services Section for inlay/onlay retainers.										06.03	
8432	Inlay/onlay retainer - metal - two surfaces	05.02	282.40 (247.70)				552.30 (484.50)		T	+L	A	
8433	Inlay/onlay retainer - metal - three surfaces	05.02	470.90 (413.10)				856.50 (751.30)		T	+L	A	
8434	Inlay/onlay retainer - metal - four or more surfaces	05.02	569.40 (499.50)				856.50 (751.30)		T	+L	A	
8436	Inlay/onlay retainer - porcelain - two surfaces	05.02	343.60 (301.40)				662.60 (581.20)		T	+L	A	
8437	Inlay/onlay retainer - porcelain - three surfaces	05.02	566.30 (496.80)				1029.50 (903.10)		T	+L	A	
8438	Inlay/onlay retainer - porcelain - four or more surfaces	05.02	685.90 (601.70)				1029.50 (903.10)		T	+L	A	
8617	Retainer cast metal (Maryland type retainer)	06.03	282.40 (247.70)				552.30 (484.50)		T	+L	A	
	Use for Maryland type bridges; Report per retainer; See codes 8415 to 8418 for pontics.											
BRIDGE RETAINERS – CROWNS												
	A crown retainer for a bridge that gains retention, support and stability from a tooth.										06.03	
8441	Crown retainer - full cast metal	05.02	726.10 (636.90)				1069.00 (937.70)		T	+L	A	
8442	Crown retainer - 3/4 cast metal	05.02	726.10 (636.90)				1069.00 (937.70)		T	+L	A	
8443	Crown retainer - porcelain/ceramic	05.02	726.10 (636.90)				1069.00 (937.70)		T	+L	A	
8444	Crown retainer - 3/4 porcelain/ceramic	05.02	726.10 (636.90)				1069.00 (937.70)		T	+L	A	
8445	Crown retainer - porcelain with metal	05.02	726.10 (636.90)				1069.00 (937.70)		T	+L	A	
8446	Crown retainer - resin with metal	05.02	726.10 (636.90)				1069.00 (937.70)		T	+L	A	
8447	Provisional crown retainer	06.03	141.10 (123.80)				211.80 (185.80)		T	(+L)	A	
	The intended use of a provisional crown retainer is to allow adequate time (of at least six weeks duration) for healing or completion of other procedures during restorative treatment and should not to be used as a temporary prosthesis. Comment: Code 8410 (Provisional crown) previously included both provisional pontics (code 8425) and provisional crown retainers (code 8447).											
OTHER FIXED PROSTHODONTIC PROCEDURES												
	See "other restorative services" for procedures related to fixed prosthesis not listed in this sub-section.										06.03	
8514	Recement bridge	06.03	63.60 (55.80)				80.70 (70.80)		T		B	

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	Use to report the recementation of a permanent inlay-, onlay-, or crown retainer - reported per retainer. May be used to report the recementation of a Maryland bridge. Report code 8133 for the recementation of a single permananet inlay, onlay or crown. Comment: This code may not be used for the recementation of temporary or provisional restorations, which is included as part of the restoration. Previously code 8133 included the recementation of bridge retainers.										
8516	Remove bridge	06.03	126.50 (111.00)				126.50 (111.00)		T		A
	This procedure involves the removal of a permananet bridge retainer - reported per retainer. Report code 8135 for the removal of a single permananet inlay, onlay or crown. Comment: This code may not be used for the removal of temporary or provisional restorations, which is included as part of the restoration. Previously code 8135 included the removal of bridge retainers.										
8518	Repair bridge	06.03	141.10 (123.80)				141.10 (123.80)		T	(+L)	A
	This procedure involves the repair or replacement of the face of a permanent crown retainer or pontic. Excludes the removal (8516) and recementation (8514) of the permanent bridge. This code may also be reported for the repair/replacement of a provisional crown retainer (8447) or pontic (8425) after a period of two months. The code may not be used for the repair/replacement of a temporary bridge, which is included as part of the restoration.										
8585	Connector bar	06.03	1139.90 (999.90)				1709.80 (1499.80)		M	+L	A
	Any bar that connects two or more inlay/onlay/crown retainers or pontics to stabilise and anchor removable overdentures. Report the appropriate retainer(s) or pontic(s) in addition to this code. Use to report Preci Bar (Dolder) System attached to inlay/onlay/crown retainers or pontics. Report code 8585 for both the prefabricated metal Preci Bar which is soldered to and plastic-wax Preci Bar which is casted directly with the inlay/onlay/crown retainers or pontics. Report the appropriate retainer(s) or pontic(s) in addition to this code.										
8586	Stress breaker	06.03	425.20 (373.00)				637.70 (559.40)		M	+L	A
	A non-rigid connector.										
8587	Coping metal	06.03	94.70 (83.10)				176.90 (155.20)		T	+L	A
	A thimble coping may utilise pins for additional retention. Generally used to parallel an abutment tooth for bridge and splints. May be similarly used to parallel an implant abutment where implant bodies are not parallel. A dome-shaped coping is generally used on an endodontically treated abutment tooth for an overdenture.										
J.	ORAL AND MAXILLO-FACIAL SURGERY										
	The branch of dentistry using surgery to treat disorders/diseases of the mouth. Surgical procedures include routine postoperative care.										06.03
EXTRACTIONS											
8201	Extraction - tooth or exposed tooth roots (first per quadrant)	06.03	63.60 (55.80)	95.30 (83.60)					T		B
	The removal of an erupted tooth or exposed tooth roots by means of elevators and/or forceps. This includes the routine removal of tooth structure and suturing when necessary. Report per tooth. The removal of more than one exposed root of the same tooth should be reported as one extraction. When a normal extraction fails and residual tooth roots are surgically removed during the same visit, code 8937 should be reported.										
8202	Extraction - each additional tooth or exposed tooth roots	06.03	25.60 (22.50)	38.40 (33.70)					T		B

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	To be reported for an additional extraction in the same quadrant at the same visit.											
SURGICAL EXTRACTIONS												
	Report code 8220 when sutures are provided by the practitioner.										06.03	
8213	Surgical removal of residual roots, first tooth - per tooth	06.03	274.70 (241.00)							T		S
	This procedure requires mucoperiosteal flap elevation with bone removal, removal of tooth roots and closure. Report per tooth. The removal of more than one root of the same tooth should be reported as one surgical removal. A residual root is defined as the remaining root structure following the loss of the major portion (over 75%) of the crown.											
8214	Surgical removal of residual roots, second and subsequent teeth's roots	04.00	211.80 (185.80)							T		S
8937	Surgical removal of tooth	06.03	274.70 (241.00)	370.80 (325.30)						T		S
	This procedure requires mucoperiosteal flap elevation with bone removal, removal of the tooth and closure. Use code 8937 for the surgical removal of residual tooth roots following the failure of a normal extraction during the same visit.											
8941	Surgical removal of impacted tooth - first tooth	06.03	455.40 (399.50)	598.90 (525.40)						T		S
	Use to report when the occlusal surface of the tooth is covered by soft tissue and/or bone. This procedure requires mucoperiosteal flap elevation with or without bone removal, removal of the tooth and closure.											
8943	Surgical removal of impacted tooth - second tooth	04.00	244.30 (214.30)	322.70 (283.10)						T		S
8945	Surgical removal of impacted tooth - third and subsequent teeth	04.00	138.80 (121.80)	183.10 (160.60)						T		S
8953	Surgical removal of residual roots, first tooth - per tooth	06.03		370.80 (325.30)						T		S
	This procedure requires mucoperiosteal flap elevation with bone removal, removal of tooth structure and closure. Report per tooth. The removal of more than one exposed root of the same tooth should be reported as one surgical removal. A residual root is defined as the remaining root structure following the loss of the major portion (over 75%) of the crown. Note 1: Maxillo-Facial Surgeons - See Surgery Guidelines, Notes 2 and 3 for the removal of residual tooth roots of each subsequent tooth. Report per tooth. Note 2: General Dental Practitioners to report codes 8213 and 8214.											
OTHER SURGICAL PROCEDURES												
8517	Reimplantation of avulsed tooth (include stabilisation)	05.04	146.90 (128.90)					220.40 (193.30)		T	+L	S
8909	Oral antral fistula closure	04.00	643.90 (564.80)	965.80 (847.20)								S
8911	Caldwell-Luc procedure	04.00	251.90 (221.00)	377.90 (331.50)								S
8917	Biopsy of oral tissue - soft	06.03	160.60 (140.90)	214.10 (187.80)			214.10 (187.80)			M		S
	Incisional/excisional (e.g. epulis). This procedure does not include the cost of the essential pathological evaluations.											

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8919	Biopsy of bone - needle	05.02	247.20 (216.80)	370.80 (325.30)					M		S
8921	Biopsy – extra-oral bone/soft tissue	05.02	404.50 (354.80)	606.60 (532.10)					M		S
8961	Tooth transplantation	06.03	552.90 (485.00)	829.30 (727.50)					T	+L	S
	See Surgery Guidelines, Notes 2 and 3.										
8965	Peripheral neurectomy	04.00	552.90 (485.00)	829.30 (727.50)							S
8966	Repair of oronasal fistula (local flaps)	04.00	769.10 (674.60)	1153.70 (1012.00)							S
8981	Surgical exposure of impacted or unerupted teeth to aid eruption	06.03	507.40 (445.10)	691.30 (606.40)		691.30 (606.40)			T		S
	An incision is made and the tissue is reflected and bone removed as necessary to expose the crown. This procedure may include but is not limited to a situation whereby an attachment is laced to facilitate eruption. In some instances, a free soft tissue graft is needed as a concurrent but separate procedure. Comment: The orthodontic attachment is usually supplied by the referring orthodontist.										
8983	Corticotomy - first tooth	04.00	367.20 (322.10)	550.80 (483.20)					T		S
8984	Corticotomy - each additional tooth	04.00	186.20 (163.30)	279.30 (245.00)					T		S
ALVEOLOPLASTY											
8957	Alveolotomy or alveolectomy (including extractions)	06.03	337.20 (295.80)	505.90 (443.80)					M		S
	Report per jaw.										
9003	Reposition mental foramen and nerve - per side	05.02	768.10 (673.80)	1152.10 (1010.60)					M	+L	S
9004	Lateralization of inferior dental nerve	05.02	1237.60 (1085.60)	1856.50 (1628.50)							S
VESTIBULOPLASTY											
	Any of a series of surgical procedures designed to increase relative alveolar ridge height.										06.03
8997	Sulcoplasty / Vestibuloplasty	05.02	1267.70 (1112.00)	1901.50 (1668.00)		1901.50 (1668.00)			M	+L	S
SURGICAL EXCISION OF SOFT TISSUE LESIONS											
8971	Excision of tumour of the soft tissue	04.00	247.20 (216.80)	370.80 (325.30)		370.80 (325.30)					S
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS											
8967	Surgical removal of jaw cyst - intra-oral approach	05.02	768.10 (673.80)	1152.10 (1010.60)					M		S
8969	Surgical removal of jaw cyst - extra-oral approach	05.02	1230.40 (1079.30)	1845.60 (1618.90)					M		S
8973	Surgical excision of tumours of the jaw	05.02	1230.40 (1079.30)	1845.60 (1618.90)					M		S
9290	Maxillectomy - Alveolus only, Level I	06.03									

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	Report per side.											
9292	Maxillectomy - Alveolus and sinus or nasal floor, Level II	06.03										
	Report per side.											
9294	Maxillectomy - Alveolus, sinus, nasal floor and zygoma excluding orbital rim Level III	06.03										
	Report per side.											
9296	Maxillectomy - Alveolus, sinus, nasal floor and zygoma including orbital rim Level IV	06.03										
	Report per side.											
9298	Maxillectomy - Alveolus, sinus, nasal floor, zygoma, orbital rim and pterygoid plates Level V	06.03										
	Report per side.											
9300	Hemiresection of jaw including condyle and coronoid process	06.03										
	Report per side.											
EXCISION OF BONE TISSUE												
8975	Hemiresection of jaw excluding condyl	06.03	1292.50 (1133.80)	1938.70 (1700.60)						M		S
	Include splintage of segments.											
8987	Reduction of mylohyoid ridges - per side	04.00	552.90 (485.00)	829.30 (727.50)						+L		S
8989	Removal torus mandibularis	04.00	552.90 (485.00)	829.30 (727.50)						+L		S
8991	Removal of torus palatinus	04.00	552.90 (485.00)	829.30 (727.50)						+L		S
8993	Surgical reduction of osseous tuberosity - per side	06.03	247.20 (216.80)	370.80 (325.30)						M	+L	S
	See procedure code 8971 for excision of denture granuloma.											
SURGICAL INCISION												
8731	Incision & drainage of abscess - intra-oral	06.03	101.40 (88.90)				152.10 (133.40)					A
	Periodontal abscess - treatment of acute phase (with or without flap procedure).											
8908	Surgical removal of roots from maxillary antrum	06.03	839.90 (736.80)	1259.90 (1105.20)								S
	Involves Caldwell-Luc and closure of oral antral communication.											
9011	Incision & drainage of abscess - intra-oral (pyogenic)	05.02	157.30 (138.00)	235.80 (206.80)						M		S
9013	Incision & drainage of abscess - extra-oral (pyogenic)	06.03	215.10 (188.70)	322.70 (283.10)						M		S
	E.g., Ludwig's angina.											
9017	Decortication, saucerisation and sequestrectomy	06.03	1138.30 (998.50)	1707.50 (1497.80)								S
	For osteomyelitis of the mandible.											

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9019	Sequestrectomy - intra oral per sextant and or ramus	05.02	247.20 (216.80)	370.80 (325.30)						M		S
TREATMENT OF FRACTURES												
Alveolus Fractures												
9024	Dento-alveolar fracture - per sextant	04.00	277.20 (243.20)	415.80 (364.70)							+L	S
Mandibular Fractures												
9025	Mandible fracture - closed reduction	06.03	613.90 (538.50)	920.90 (807.80)								S
	Includes intermaxillary fixation.											
9027	Mandible fracture - compound, with eyelet wiring	04.00	862.20 (756.30)	1293.30 (1134.50)								S
9029	Mandible fracture - splints	06.03	954.70 (837.50)	1432.10 (1256.20)							+L	S
	Metal cap splintage or Gunning's splints.											
9031	Mandible fracture - open reduction	06.03	1415.10 (1241.30)	2122.60 (1861.90)							+L	S
	Includes restoration of occlusion by splintage.											
Maxillary Fractures												
9035	Maxilla fracture - Le Fort I or Guerin	06.03	863.80 (757.70)	1295.60 (1136.50)							+L	S
	When open reduction is required for Codes 9035 and 9037, Modifier 8010 may be applied.											
9037	Maxilla fracture - Le Fort II or middle third face	06.03	1415.10 (1241.30)	2122.60 (1861.90)							+L	S
	When open reduction is required for Codes 9035 and 9037, Modifier 8010 may be applied.											
9039	Maxilla fracture - Le Fort III or craniofacial disjunction	06.03	2029.50 (1780.30)	3044.30 (2670.40)							+L	S
	Includes comminuted mid-facial fractures requiring open reduction and splintage.											
Zygoma/Orbital/Antral Fractures												
9041	Zygomatic arch fracture - closed reduction	06.03	613.90 (538.50)	920.90 (807.80)								S
	Gillies or temporal elevation.											
9043	Zygomatic arch fracture - open reduction	06.03	1230.40 (1079.30)	1845.60 (1618.90)								S
	Unstable and/or comminuted zygoma, treatment by open reduction or Caldwell-Luc operation											
9045	Zygomatic arch fracture - open reduction (requiring osteosynthesis and/or grafting)	04.00	1843.30 (1616.90)	2765.00 (2425.40)								S
9046	Placement of Zygomaticus fixture, per fixture	05.02	1217.60 (1068.10)	1826.30 (1602.00)								S
Nasal Fractures												
9280	Open reduction and fixation of nasal fractures	04.00										
9282	Manipulation and immobilisation of nasal fracture	04.00										

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TEMPOROMANDIBULAR JOINT												
	Procedures which are an integral part of a primary procedure should not be reported separately.											06.03
8172	Cost of orthotic appliance	06.03	-	-	-	-	-	-	-	-	-	
	Comment: Applicable to pre-fabricated devices. See Rule 002 and Modifier 8025 for direct material costs.											
8850	Treatment of MPDS - first visit	04.00	97.20 (85.30)		145.90 (128.00)		145.90 (128.00)					A
8851	Treatment of MPDS - subsequent visit	04.00	51.20 (44.90)		76.80 (67.40)		76.80 (67.40)					A
8852	Occlusal orthotic appliance	06.03	244.30 (214.30)	321.90 (282.40)	321.90 (282.40)	321.90 (282.40)	321.90 (282.40)				+L	S
	Presently includes splints provided for treatment of temporomandibular joint dysfunction and NTI Tention Supression System (NTI-tss) devices.											
9053	Coronoidectomy (intra-oral approach)	04.00	767.50 (673.20)	1151.30 (1009.90)								S
9074	Tmj arthroscopy diagnostic	04.00	610.80 (535.80)	916.20 (803.70)								S
9075	Condylectomy, coronoidectomy or both	04.00	1534.50 (1346.10)	2301.80 (2019.10)								S
9076	TMJ artrocentesis	04.00	337.20 (295.80)	505.90 (443.80)								S
9077	TMJ intra-articular injection	04.00	92.00 (80.70)	138.10 (121.10)								S
9079	Trigger point injection	04.00	71.80 (63.00)	107.80 (94.60)								S
9081	Condylectomy (Ward/Kostecka)	06.03	613.90 (538.50)	920.90 (807.80)								S
	For Codes 9081, 9083 and 9092 the full fee may be charged per side.											
9083	TMJ srthroplasty	06.03	1534.50 (1346.10)	2301.80 (2019.10)								S
	For Codes 9081, 9083 and 9092 the full fee may be charged per side.											
9085	Reduction of TMJ disloc w/o anaesthetic	04.00	122.10 (107.10)	183.10 (160.60)								S
9087	Reduction of TMJ disloc w/ anaesthetic	04.00	247.20 (216.80)	370.80 (325.30)								S
9089	Reduction of TMJ disloc w/ anaesthetic and immobilisation	04.00	613.90 (538.50)	920.90 (807.80)								S
9091	Reduction of TMJ dislocation - open reduction	04.00	1534.50 (1346.10)	2301.80 (2019.10)								S
9092	Joint reconstruction	06.03	4096.80 (3593.70)	6145.20 (5390.50)							+L	S
	Total joint reconstruction with alloplastic material or bone (includes condylectomy and coronoidectomy) For Codes 9081, 9083 and 9092 the full fee may be charged per side.											

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REPAIR OF TRAUMATIC WOUNDS												
8192	Suture - minor	06.03	313.40 (274.90)									S
	Use to report the suturing of recent small wounds. Excludes the closure of surgical incisions.											
COMPLICATED SUTURING												
	Reconstruction requiring delicate handling of tissues and undermining for meticulous closure. Excludes the closure of surgical incisions.	06.03										
9021	Suture - reconstruction, minor (excludes closure of surgical incisions)	04.00	313.40 (274.90)	415.80 (364.70)								S
9023	Suture - reconstruction, major (excludes closure of surgical incisions)	04.00	583.40 (511.80)	875.10 (767.60)								S
OTHER REPAIR PROCEDURES												
8958	Emergency tracheotomy	04.00	283.40 (248.60)	425.10 (372.90)								
8959	Pharyngostomy	04.00	283.40 (248.60)	425.10 (372.90)								
8962	Harvest iliac crest graft	04.00	203.80 (178.80)	250.50 (219.70)								S
8963	Harvest rib graft	04.00	233.80 (205.10)	350.70 (307.60)								S
8964	Harvest cranium graft	04.00	183.10 (160.60)	274.70 (241.00)								S
8977	Surgical repair of maxilla or mandible - major	06.03	1291.50 (1132.90)	1937.20 (1699.30)								S
	Major repairs of upper or lower jaw (i.e. by means of bone grafts or prosthesis, with jaw splintage) Modifiers 8005 and 8006 are not applicable in this instance. The full fee may be charged irrespective of whether this procedure is carried out concomitantly with procedure 8975 or as a separate procedure.											
8979	Harvesting of autogenous grafts (intra-oral)	04.00	106.50 (93.40)	159.80 (140.20)		159.80 (140.20)						S
8985	Frenulectomy/frenulotomy	04.00	337.20 (295.80)	505.90 (443.80)		505.90 (443.80)						S
9005	Alveolar ridge augmentation - total (by bone graft)	05.02	1292.50 (1133.80)	1938.70 (1700.60)		1938.70 (1700.60)				M	+L	S
9007	Alveolar ridge augmentation - total (by alloplastic material)	05.02	813.50 (713.60)	1220.30 (1070.40)						M	+L	S
9008	Alveolar ridge augmentation - one to two tooth sites	05.02	251.50 (220.60)	460.10 (403.60)		460.10 (403.60)				M	+L	S
9009	Alveolar ridge augmentation - three across 3 or more tooth sites	05.02	559.10 (490.40)	838.60 (735.60)		838.60 (735.60)				M	+L	S
9010	Sinus lift procedure	05.02	839.90 (736.80)	1259.90 (1105.20)		1259.90 (1105.20)				M	+L	S
9032	Reduction of masseter muscle and bone - extra-oral approach Eg., for treatment of benign masseteric hypertrophy; extraoral approach (Alt Code: CPT 21295)	06.03										
9033	Reduction of masseter muscle and bone - intra-oral approach Eg., for treatment of benign masseteric hypertrophy; intraoral approach (Alt Code: CPT 21296)	06.03										

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9048	Surgical removal of internal fixation devices, per site	05.02	236.40 (207.40)	354.60 (311.10)							S
Functional Correction of Malocclusion											
	For Codes 9047 to 9072 the full fee may be charged.									06.03	
9047	Osteotomy - open with stabilisation	06.03	2579.80 (2263.00)	3869.70 (3394.50)						+L	S
	Operation for the improvement or restoration of occlusal and masticatory function, e.g. bilateral osteotomy, open operation (with immobilisation)										
9049	Osteotomy - mandible body, anterior segmental	06.03	2150.10 (1886.10)	3225.00 (2828.90)						+L	S
	E.g. K��le										
9050	Osteotomy - total subapical	04.00	3932.90 (3449.90)	5899.20 (5174.70)							S
9051	Genioplasty	04.00	1230.40 (1079.30)	1845.60 (1618.90)							S
9052	Midfacial exposure	06.03	1947.80 (1708.60)	2921.70 (2562.90)							S
	For maxillary and nasal augmentation or pyramidal Le Fort II osteotomy.										
9055	Osteotomy - segmented, posterior	06.03	2150.10 (1886.10)	3225.00 (2828.90)						M +L	S
	Maxillary posterior segment osteotomy (Schukardt) - 1 or 2 stage procedure.										
9057	Osteotomy - segmented, anterior	06.03	2150.10 (1886.10)	3225.00 (2828.90)						M +L	S
	Maxillary anterior segment osteotomy (Wassmund) - 1 or 2 stage procedure.										
9059	Reconstruct maxilla - Le Fort I osteotomy, one piece	04.00	4045.60 (3548.80)	6068.30 (5323.10)						+L	S
9060	Reconstruct maxilla - Le Fort I osteotomy w/ repositioning and graft	05.02	4541.60 (3983.90)	6812.30 (5975.70)						+L	S
9061	Palatal osteotomy	04.00	1415.10 (1241.30)	2122.60 (1861.90)							S
9062	Reconstruct maxilla - Le Fort I osteotomy, multiple segments	04.00	5164.30 (4530.10)	7746.40 (6795.10)						+L	S
9063	Reconstruct maxilla - Le Fort 2 osteotomy (facial and post-traumatic deformities)	04.00	5166.90 (4532.40)	7750.30 (6798.50)						+L	S
9065	Reconstruct maxilla - Le Fort 3 osteotomy (severe congenital deformities)	06.03	7743.50 (6792.50)	11615.30 (10188.90)						+L	S
	Le Fort III osteotomy for correction of severe congenital deformities, viz. Crouzon's disease and malunited craniomaxillary disjunction.										
9066	Surgical expansion - maxillary or mandibular	06.03	1230.40 (1079.30)	1845.60 (1618.90)						M	S
	This procedure is to expand the maxilla or mandible to facilitate orthodontic aligning of constricted dental arches.										
9069	Glossectomy - partial	04.00	921.60 (808.40)	1382.40 (1212.60)							S

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9071	Geniohyoidotomy	04.00	552.90 (485.00)	829.30 (727.50)							S
9072	Close secondary oro-nasal fistula w/ bone grafting (complete procedure)	04.00	4045.60 (3548.80)	6068.30 (5323.10)						+L	S
Salivary Glands											
9093	Removal of salivary stone (Sialolithotomy)	04.00	277.20 (243.20)	415.80 (364.70)							S
9095	Excision of sublingual salivary gland	04.00	683.20 (599.30)	1024.90 (899.00)							S
9096	Excision of salivary gland - extra oral approach	04.00	1012.20 (887.90)	1518.30 (1331.80)							S
Pedicle Flaps											
	Report codes 9284, 9286 and 9288 for flaps taken for repair of post –cancer/ trauma/ tumour surgery. These are not vestibuloplasty procedures. The use of the codes are not subject to modifier use.										06.03
9284	Musculofascial flap	04.00									
9286	Musculocranial flap	04.00									
9288	Buccal fat pad (major repair)	04.00									
Repair of Frontal Bones											
	The use of codes 9274, 9275 and 9278 imply the bicoronal/ hemicoronal approach.										06.03
9274	Repair anterior table, frontal sinus and/or supraorbital rim	04.00									
9276	Repair anterior and posterior wall w/ obturation and/or cranialisation of frontal sinus	04.00									
9278	Repair medial canthal ligament (canthopexy), per side	04.00									
Cleft lip and Palat											
9220	Repair cleft hard palate - unilateral	04.00	2259.60 (1982.10)	3389.50 (2973.20)							S
9222	Repair cleft hard palate - bilateral (one procedure)	04.00	2868.40 (2516.10)	4302.50 (3774.10)							S
9224	Repair cleft hard palate - bilateral (two procedures)	04.00	4274.20 (3749.30)	6410.60 (5623.30)							S
9226	Repair cleft soft palate - w/o muscle reconstruction	04.00	1893.50 (1661.00)	2840.20 (2491.40)							S
9228	Repair cleft soft palate - w/ muscle reconstruction	04.00	2749.40 (2411.80)	4124.10 (3617.60)							S
9230	Repair submucosal cleft and/or bifid uvula - w/ muscle reconstruction	04.00	2047.10 (1795.70)	3070.60 (2693.50)							S
9232	Velopharyngeal reconstruction - uncomplicated	04.00	2106.60 (1847.90)	3159.80 (2771.80)							S
9234	Velopharyngeal reconstruction - complicated	04.00	2252.50 (1975.90)	3378.60 (2963.70)							S
9238	Repair oronasal fistula (one procedure)	04.00	1288.40 (1130.20)	1932.50 (1695.20)							S
9240	Repair oronasal fistula (two procedures)	04.00	2247.70 (1971.70)	3371.60 (2957.50)							S
9246	Secondary periosteal flaps	04.00	1123.30 (985.40)	1685.00 (1478.10)							S

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9248	Lipadhesion	04.00	419.90 (368.30)	629.90 (552.50)							S
9250	Repair cleft lip - unilateral w/o muscle reconstruction	04.00	739.60 (648.80)	1109.40 (973.20)							S
9252	Repair cleft lip - unilateral w/ muscle reconstruction	04.00	1002.80 (879.60)	1504.30 (1319.60)							S
9254	Repair cleft lip - bilateral w/o muscle reconstruction	04.00	1032.80 (906.00)	1549.30 (1359.00)							S
9256	Repair cleft lip - bilateral w/ muscle reconstruction	04.00	1595.60 (1399.60)	2393.40 (2099.50)							S
9258	Repair anterior nasal floor	04.00	402.90 (353.40)	604.30 (530.10)							S
9260	Revision of secondary cleft lip deformity - partial	04.00	402.90 (353.40)	604.30 (530.10)							S
9262	Revision of secondary cleft lip deformity - total w/ muscle reconstruction	04.00	910.30 (798.50)	1365.40 (1197.70)							S
9264	Abbe-flap - two stages	04.00	1030.80 (904.20)	1546.20 (1356.30)							S
9266	Reconstruct columella	04.00	609.30 (534.50)	913.90 (801.70)							S
9268	Reconstruct nose due to cleft deformity - partial	04.00	774.30 (679.20)	1161.40 (1018.80)							S
9270	Reconstruct nose due to cleft deformity - complete	04.00	1223.70 (1073.40)	1835.50 (1610.10)							S
9272	Paranasal augmentation for nasal base deviation	04.00	609.30 (534.50)	913.90 (801.70)							S
K.	ORTHODONTIC SERVICES										
	The branch of dentistry used to correct malocclusions of the mouth and restore it to proper alignment and function. Includes all services/procedures concerned with the supervision, guidance and correction of the growing and mature dentofacial structures.										06.03
	REMOVABLE APPLIANCE THERAPY										
	Removable indicates patient can remove; includes appliances for limited orthodontic treatment (e.g., partial treatment to open spaces or upright of a tooth) and minor orthodontic treatment to control harmful habits (e.g., thumb sucking and tongue trusing).										06.03
8862	Ortho Tx - removable appliance	04.00	713.20 (625.60)		1069.80 (938.40)					+L	A
8863	Ortho Tx - each additional removable appliance	06.03	358.40 (314.40)		537.70 (471.70)					+L	A
	Limitation: Code 8862 may only be charged once per malocclusion. A maximum of two additional removable appliances per treatment plan may be charged.										
	FUNCTIONAL APPLIANCE THERAPY										
	A removable functional appliance is an appliance with no fixed dental component which is designed to harness the forces generated by the muscles of mastication and the associated soft tissues of the oro-facial region. This appliance incorporates components which act on both the maxillary and mandibular arches and should be differentiated from a simple removable appliance including appliances incorporating an anterior and posterior bite plane. Orthodontic treatment by means of a functional appliance is usually followed by comprehensive orthodontic treatment utilising fixed orthodontic appliances. When both phases of orthodontic treatment is provided by the same practitioner, the fees levied for treatment by means of the functional appliance, will be deducted from the fee quoted for comprehensive orthodontic treatment.										06.03
8858	Ortho Tx - functional appliance	06.03	1284.80 (1127.00)		1927.10 (1690.40)					+L	A
	If additional functional appliances are required, +L can be charged but no further fee.										

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FIXED APPLIANCE THERAPY											
Fixed Appliance Therapy - Partial											
	The intention of this phase in treatment is to intercept and modify the development of skeletal, dental and functional components of developing malocclusion usually in the mixed dentition. When the preliminary/interceptive phase(s) of orthodontic treatment is followed by comprehensive orthodontic treatment and both phases of orthodontic treatment is provided by the same practitioner, the fees levied for preliminary/interceptive orthodontic treatment will be deducted from the fee quoted for comprehensive orthodontic treatment.										06.03
8861	Ortho Tx - partial fixed appliance - minor	04.00	854.50 (749.60)		1281.70 (1124.30)						A
8865	Ortho Tx - partial fixed appliance - one arch	04.00	2279.30 (1999.40)		3418.90 (2999.00)						A
8866	Ortho Tx - partial fixed appliance - both arches	04.00	3134.80 (2749.80)		4702.10 (4124.60)						A
Fixed Appliance Therapy - Comprehensive: Single Arch											
	This form of therapy requires the placement of fixed bands and or brackets on the majority of teeth within an arch and the subsequent placement of active arch wires to treat the case through to completion of active treatment excluding the retention phase.										06.03
8867	Ortho Tx - fixed appliance - one arch	04.00	2450.00 (2149.10)		3674.90 (3223.60)						A
8868	Ortho Tx - fixed appliance - one arch, moderate	04.00	3022.00 (2650.90)		4533.00 (3976.30)						A
8869	Ortho Tx - fixed appliance - one arch, severe	04.00	3534.60 (3100.50)		5301.80 (4650.70)						A
Fixed Appliance Therapy - Comprehensive: Both Arches											
	This form of therapy requires the placement of fixed bands and or brackets on the majority of teeth within both arches and the subsequent placement of active arch wires to treat the case through to completion of active treatment excluding the retention phase.										06.03
8873	Ortho Tx - fixed appliance - both arches, Class 1 mild	04.00	4483.60 (3933.00)		6725.40 (5899.50)						A
8875	Ortho Tx - fixed appliance - both arches, Class 1 moderate	04.00	5504.10 (4828.20)		8256.00 (7242.10)						A
8877	Ortho Tx - fixed appliance - both arches, Class 1 severe	04.00	6416.40 (5628.40)		9624.60 (8442.60)						A
8879	Ortho Tx - fixed appliance - both arches, Class 1 severe w/ complications	04.00	7210.90 (6325.40)		10816.20 (9487.90)						A
8881	Ortho Tx - fixed appliance - both arches, Class 2/3 mild	04.00	6416.40 (5628.40)		9624.60 (8442.60)						A
8883	Ortho Tx - fixed appliance - both arches, Class 2/3 moderate	04.00	7210.90 (6325.40)		10816.20 (9487.90)						A
8885	Ortho Tx - fixed appliance - both arches, Class 2/3 severe	04.00	8094.80 (7100.70)		12142.10 (10651.00)						A
8887	Ortho Tx - fixed appliance - both arches, Class 2/3 severe w/ complications	04.00	9120.30 (8000.30)		13680.50 (12000.40)						A
Lingual Orthodontics - Comprehensive: Single Arch											
	This form of therapy requires the placement of bands and or brackets on the lingual aspect of the majority of teeth within at least one arch and must include the placement of active arch wires.										06.03
8841	Ortho Tx - fixed lingual appliance - one arch	04.00	4604.70 (4039.20)		6906.90 (6058.70)						A
8842	Ortho Tx - fixed lingual appliance - one arch, moderate	04.00	5411.50 (4746.90)		8117.20 (7120.40)						A

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8843	Ortho Tx - fixed lingual appliance - one arch, severe	04.00	6165.60 (5408.40)		9248.40 (8112.60)						A
Lingual Orthodontics - Comprehensive: Both Arches											
8874	Ortho Tx - fixed lingual appliance - both arches, Class 1 mild	04.00	8784.20 (7705.40)		13176.20 (11558.10)						A
8876	Ortho Tx - fixed lingual appliance - both arches, Class 1 moderate	04.00	10284.60 (9021.60)		15426.80 (13532.30)						A
8878	Ortho Tx - fixed lingual appliance - both arches, Class 1 severe	04.00	11671.80 (10238.40)		17507.50 (15357.50)						A
8880	Ortho Tx - fixed lingual appliance - both arches, Class 1 severe w/ complications	04.00	12950.80 (11360.40)		19426.00 (17040.40)						A
8882	Ortho Tx - fixed lingual appliance - both arches, Class 2/3 mild	04.00	10721.60 (9404.90)		16082.30 (14107.30)						A
8884	Ortho Tx - fixed lingual appliance - both arches, Class 2/3 moderate	04.00	11994.00 (10521.10)		17990.80 (15781.40)						A
8886	Ortho Tx - fixed lingual appliance - both arches, Class 2/3 severe	04.00	13358.30 (11717.80)		20037.40 (17576.70)						A
8888	Ortho Tx - fixed lingual appliance - both arches, Class 2/3 severe w/ complications	04.00	14863.90 (13038.50)		22295.70 (19557.60)						A
OTHER ORTHODONTIC SERVICES											
8846	Repair orthodontic appliance - removable	04.00	58.40 (51.20)		87.60 (76.80)					+L	A
8847	Replace orthodontic appliance - removable	04.00	201.70 (176.90)		302.60 (265.40)					+L	A
8848	Repair orthodontic appliance - fixed	06.03	86.40 (75.80)		129.60 (113.70)					+L	A
	As a result of the patient's negligence. Report per retainer.										
8849	Retainer (orthodontic)	04.00	201.70 (176.90)		302.60 (265.40)					+L	A
8890	Monthly instalment ortho tx	06.03	-		-						A
	Refer to code number of treatment.										
8891	Orthodontic transfer	06.03	-		-						A
	Limitation: Benefit by arrangement.										
8892	Orthodontic re-treatment	06.03	-		-						A
	Limitation: Benefit by arrangement.										
L. SUPPLEMENTARY SERVICES											
	The branch of dentistry for unclassified treatment including palliative care and anaesthesia.										06.03
ANAESTHESIA											
8499	General anaesthetic	05.02	-								B
8141	Inhalation sedation - first 15 minutes or part thereof	06.03	46.60 (40.90)								B
	No additional fee/benefit to be charged for gases used in the case of items 8141 and 8143.										
8143	Inhalation sedation - each addnl 15 minutes	06.03	24.10 (21.10)								B
	See 8141 descriptor.										

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8144	Intravenous sedation	04.00	27.90 (24.50)							B
8145	Local anaesthetic - per visit	06.03	40.40 (35.40)							B
	Use for infiltrative anaesthesia (anaesthetic agent is infiltrated directly into the surgical site by means of an injection). Excludes topical anaesthesia (anaesthetic agent is applied topically to the mucosa/skin). Report per visit. Comment: The fee for topical anaesthesia are considered to be part of, and included in the fee for the local anaesthesia (injection). Code 8145 includes the use of the Wand.									
8147	Monitoring equipment for intravenous sedation	06.03	99.30 (87.10)							B
	Applies to own monitoring equipment in rooms for procedures performed under intravenous sedation									
PROFESSIONAL VISITS										
8129	Office/hospital visit – after regularly scheduled hours	06.03	155.90 (136.80)							B
	Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to appropriate code numbers for actual services rendered. After regularly scheduled hours is defined as weekends and night visits between 18h00 and 07h00 the following day. Limitation: Code 8129 may only be reported for emergency treatment rendered outside normal working hours. Not applicable where a practice offers an extended hours service as the norm.									
8140	House/extended care facility/hospital call	06.03	103.20 (90.50)			103.20 (90.50)				B
	Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report per visit in addition to reporting appropriate code numbers for actual services performed. Limitation: The fee/benefit for house/extended care facility/hospital calls are limited to five calls per treatment plan.									
8903	House/Hosp/Nursing home consultation - MFOS	04.00		115.50 (101.30)						S
8904	House/Hosp/Nursing home consultation (subsequent) - MFOS	06.03		76.80 (67.40)						S
	"Subsequent consultation" shall mean, in connection with items 8904 and 8907, a consultation for the same pathological condition provided that such consultation occurs within six months of the first consultation.									
8905	After regularly hours consultation - MFOS	04.00		169.20 (148.40)						S
8907	House/Hosp/Nursing home consultation (maximum per week) - MFOS	06.03		192.40 (168.80)						S
	See Code 8904 descriptor.									
9203	House/Hosp/Nursing home consultation - Oral pathologist	04.00						115.50 (101.30)		
9207	After hours visit - Oral pathologist	04.00						169.20 (148.40)		
DRUGS, MEDICAMENTS AND MATERIALS										
8109	Infection control/barrier techniques	06.03	9.31 (8.17)							B
	Comment: This is typically reported on a "per visit" basis for new rubber gloves, masks, etc. provided by the dentist. Report per provider per visit.									
8110	Sterilized instrumentation	06.03	24.00 (21.10)							S
	Limitation: The use of this code is limited to autoclaved, vapour or heat sterilised instruments (i.e. set(s) of long handled instruments and/or forceps) provided by the dentist/hygienist for use in the surgery. Report per visit.									

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8183	Therapeutic drug injection Not applicable to local anaesthetic.	06.03	27.90 (24.50)									B
8220	Cost of suture material Comment: Use in conjunction with procedure(s) when suture material is provided by the practitioner. Report per pack. See Rule 002 and Modifier 8025 for direct material costs.	06.03	-	-	-	-	-	-				B
8304	Rubber dam per arch The use of this code is limited to selected procedures for benefit purposes. These procedures are identified throughout the NHRPL.	06.03	49.70 (43.60)									B
8306	Cost of MTA Comment: See Rule 002 and Modifier 8025 for direct material costs.	06.03	-				-					B
8310	Supply of bleaching materials See Rule 002 and Modifier 8025 for direct material costs. Limitation: Benefit by arrangement.	06.03	-									
ADMINISTRATIVE AND LABORATORY SERVICES												
8099	Dental laboratory service Use to submit dental laboratory services. See Rule 003.	06.03	-	-	-	-	-	-				
8106	Special report Special written reports such as insurance forms requiring more than the information conveyed in the usual dental communications or standard reporting form. Excludes pre-treatment estimate and orthodontic treatment/payment plan.	06.03	106.30 (93.20)	106.30 (93.20)	106.30 (93.20)	106.30 (93.20)	106.30 (93.20)	106.30 (93.20)				A
8111	Dental testimony Use to report dento-legal fees when the practitioner is present at Court at the request of an advocate or attorney. Report per hour.	06.03										
8120	Treatment plan completed Use to report the completion of a treatment plan effected from an oral evaluation – See Rule 008.	06.03	-	-	-	-	-	-				
8139	Appointment not kept /30min Comment: By arrangement with patient	06.03	-	-	-	-	-	-				B
MISCELLANEOUS SERVICES												
Palliative Treatment												
8131	Emergency dental treatment This code is intended to be used for emergency treatment to alleviate dental pain but is not curative - report per visit. This code should not be used when more adequately described procedures exists and may not be reported with other procedure codes (diagnostic procedures and professional visits excluded).	06.03	63.60 (55.80)					129.60 (113.70)		T		B
8166	Application of desensitising resin, per tooth This procedure involves the application of adhesive resins on a cervical and/or root surface and should not to be used for bases, liners, or adhesives under restorations - report per tooth.	06.03	41.90 (36.80)							T		B
8167	Application of desensitising medicament, per visit	06.03	48.90 (42.90)									B

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	This procedure involves the application of topical fluoride on teeth and/or root surfaces and should not be used for bases, liners, or adhesives under restorations - report per visit (irrespective of number of teeth treated). The intention of this code is to treat persistent pain and not to prevent decay. Fluoride application is considered treatment for caries control – See codes 8161 and 8162. Comment: This code should not be reported together with codes 8161 and 8162.											
8165	Sedative filling	06.03	63.60 (55.80)							T	+L	E
	The intention of this code is to report a temporary restoration to relieve pain. It should not be used as a temporary restoration in conjunction with root canal therapy, a base or liner under a restoration. Use this code to report a ZOE restoration or ART technique. May not be reported with other procedure codes on the same visit for a tooth.											
Post Surgical Complications												
8931	Treatment of post-extraction haemorrhage	06.03	46.60 (40.90)	279.30 (245.00)								S
	Involves the treatment of local haemorrhage following extraction. Report per visit. Excludes treatment of bleeding in the case of blood dyscrasias (8933), e.g. haemophilia. Routine post operative visits for irrigation, dressing change and suture removal are considered to be part of, and included in the fee for the surgical service.											
8933	Treatment of haemorrhage (blood dyscracias)	04.00	643.90 (564.80)	965.80 (847.20)								S
8935	Treatment of septic socket	06.03	46.60 (40.90)	72.90 (63.90)								S
	Involves the treatment of localised inflammation of the tooth socket following extraction due to infection or loss of blood clot; osteitis. Report per visit. Routine postoperative visits for irrigation, dressing change and suture removal are considered to be part of, and included in the fee for, the surgical service.											
Bleaching												
8308	External bleaching - per arch	06.03								M		A
	Comment: (1) The unpredictability and lack of permanence of this procedure should be pointed out, and alternative procedures discussed with the patient. (2) The benefits provided by some medical schemes for external bleaching may be subject to pre-authorisation.											
8309	Home bleaching - instructions and applicator	06.03									+L	A
	See code 8310 in the section 'Adjunctive general services' for materials supplied Limitation: Benefits by arrangement.											
8311	Home bleaching - subsequent visit	06.03										A
	Limitation: A maximum of three additional visits may be charged. Benefits by arrangement.											
8325	Internal bleaching - per tooth	06.03	150.50 (132.00)					225.80 (198.10)		T		A
	Report code 8304 (application of a rubber dam) in addition to this code.											
8327	Internal bleaching - each additional visit	06.03	72.20 (63.30)					108.30 (95.00)		T		A
	Comment: (1) Report the application of a rubber dam code (8304) in addition to this code. (2) The submission of fees is limited to two additional visits.											
Unclassified Treatment												
8158	Enamel microabrasion	06.03	58.20 (51.10)									
	This procedure involves the removal of superficial enamel defects due to decalcification or altered mineralisation. It is typically used for complex procedures when removing stain from anterior teeth (e.g., fluorosis stain) and should not be confused with air abrasion. Submit per visit.											

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8168	Behavior management	06.03									B
	Comment: (1) May be reported in addition to treatment provided, when the patient is developmentally disabled, mentally ill, or is especially uncooperative and difficult to manage, resulting in the dental staff providing additional time, skill and/or assistance to render treatment. (2) The Code can only be billed where an office treatment requires extraordinary effort and is the only alternative to general anaesthesia. Includes any and all pharmacological, psychological, physical management adjuncts required or utilised. (3) Notation and justification must be written in the patient record identifying the specific behaviour problem and the technique used to manage it. (4) Report in 15-minute units. (maximum 4 units per visit and allowed once per patient per day) Limit of 12 units per year. (5) If requested, the report must be made available at no charge. (6) The benefits provided by some medical schemes for behaviour management may be subject to pre-authorisation.										
8551	Occlusal adjustment - major	06.03	402.40 (353.00)			603.50 (529.40)		603.50 (529.40)			A
	Comment: (1) A complete occlusal adjustment involves the grinding of teeth to the equivalent of two or more quadrants. (2) Several appointments of varying length and sedation to attain relaxation of the muscularity muscles may be necessary. Submit code 8551 for payment at the last visit if several appointments to complete the procedure are required.										
8553	Occlusal adjustment - minor	06.03	140.30 (123.10)			192.40 (168.80)	192.40 (168.80)	192.40 (168.80)			A
	An occlusal adjustment involves the grinding of the occluding surfaces of teeth to develop harmonious relationships between each other, their supporting structures, muscles of mastication and temporomandibular joints. Comment: (1) Partial occlusal adjustment for the relief of symptomatic teeth involves the selective grinding of teeth to the equivalent of one quadrant or less. (2) Payment for this procedure is limited to one visit per treatment plan. (3) May not be submitted for the adjustment of dentures or restorations provided as part of a treatment plan (including opposing teeth).										
9099	Unlisted dental procedure or service (By report)	06.03	-								
	The intention of this code is to report a dental procedure or service which is not adequately described by a code. Describe procedure.										
MODIFIERS											
8001	Assistant surgeon - specialist (1/3 of the appropriate benefit)										06.03
8003	Minimum assistant surgeon	06.03	117.93 (103.45)	117.93 (103.45)		117.93 (103.45)					
	The minimum fee/benefit for surgical assistant services is identified by adding Modifier 8003 to the primary procedure code – See Rule 009.										
8005	Maximum multiple procedures (same incision) - MFO surgeon	06.03	183.09 (160.61)	183.09 (160.61)		183.09 (160.61)					
	When multiple surgical procedures through the same incision are performed on the same day or at the same session by the same provider, the primary procedure may be reported as listed. The maximum fee/benefit for each additional procedure should be identified by adding Modifier 8005 to the additional procedure code.										
8006	Multiple surgical procedures - third and subsequent procedures (50% of the appropriate benefit)										06.03
8007	Assistant surgeon - general dental practitioner (15% of the appropriate benefit)										06.03
8008	Emergency surgery - after hours (PLUS 25% of the appropriate benefit)										06.03
8009	Multiple surgical procedures - second procedure (75% of the appropriate benefit)										06.03
8010	Open reduction (PLUS 75% of the appropriate benefit)										06.03
8011	Procedure accompanied by unusual circumstances (Benefit PLUS X % as determined by the practitioner and agreed upon by patient/medical scheme)										06.03
8012	Reduced services (benefit MINUS X % as determined by the practitioner)										06.03

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8013	Multiple modifiers											06.03
8023	Fabrication of inlay/onlay (PLUS 25% of the appropriate benefit)											06.03
8025	Handling fee - direct materials (26% of material cost to a maximum of R26.00)	06.03	-	-		-	-					
	When listed direct dental materials are provided by the practitioner, a handling fee may be levied by reporting Modifier 8025 in addition to the appropriate direct material code – See Rule 002.											