

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY DENTAL PRACTITIONERS, EFFECTIVE FROM 1 JANUARY 2006

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.

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.

VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

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.

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.

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.

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
	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

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B.	General coding rules	
006	<p>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.</p>	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	<p>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.</p> <p>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.</p> <p>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</p>	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
	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
	<p>The documentation and first invoice to the patient/medical scheme regarding orthodontic services will include the following information:</p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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

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	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
8002	Specialist fee/benefit (Plus 50% of the appropriate benefit)	06.03
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
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 +D Add fee/benefit for denture +L Add laboratory fee +M Add material fee	05.02
	MP Mouth Part Column M Maxilla/Mandible Q Quadrant S Sextant T Tooth	05.02
	TC Treatment Category Column A Advanced dentistry B Basic dentistry S Surgery	05.02

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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	Dental Therapy	M P	Lab	T C
8101	Oral examination	06.03	53.90 (47.30)			B
	An assessment performed on a patient to determine the patient's dental and medical health status involving an examination, diagnosis and treatment plan. It is a thorough assessment and recording of the patient's current state of oral health (extraoral and intraoral hard and soft tissues), risk for future dental disease as well as assessing general health factors that relate to the treatment of the patient. This procedure is also used to report a periodic examination on an established patient to determine any changes in a patient's dental and medical health status since a previous periodic or comprehensive examination. No further oral examination fees shall be levied until the treatment plan resulting from this assessment is completed (See Rule 008).					
8102	Comprehensive oral examination	06.03	87.00 (76.30)			B

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	<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. 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	42.00 (36.80)		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.</p> <p>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	42.00 (36.80)		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>				
8190	Consultation - second opinion or advice	06.03	-		B
	<p>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.</p> <p>It involves an examination, diagnosis and treatment proposal. The dentist may initiate further diagnostic or therapeutic services (oral examinations excluded).</p> <p>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</p>				
Periodontist/Oral Medicine					
	Codes 8701, 8703, 8705 and 8707 cannot be charged at one and the same visit.				06.03
RADIOGRAPHS/DIAGNOSTIC IMAGING					
	<p>Diagnostic radiographs/diagnostic images include interpretation.</p> <p>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.</p> <p>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.</p> <p>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.</p>				06.03
8107	Intraoral radiograph - periapical	06.03	40.40 (35.40)		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	324.20 (284.40)		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	40.40 (35.40)		B

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	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	69.40 (60.90)		B
8114	Extraoral radiograph - hand-wrist	06.03	-		B
	Use to report extraoral radiographs such as hand-wrist radiographs.				
8115	Extraoral radiograph - panoramic	04.00	161.60 (141.80)		B
8116	Extraoral radiograph - cephalometric	05.02	161.60 (141.80)		B
8118	Extraoral radiograph - skull/facial bone	05.02	-		B
8121	Oral and/or facial image (digital/conventional)	06.03	43.30 (38.00)		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					
8122	Microbiological studies	06.03			B
	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.				
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	51.70 (45.40)		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	94.20 (82.60)		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.				
TOPICAL FLUORIDE TREATMENT					
	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	51.70 (45.40)		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	51.70 (45.40)		B
	See code 8161.				
SPACE MAINTENANCE (PASSIVE APPLIANCES)					
	Passive appliances are designed to prevent tooth movement.				06.03
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

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	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/periodo 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 quit 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.					
8151	Oral hygiene instruction	06.03	42.30 (37.10)			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	30.90 (27.10)			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	38.30 (33.60)	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.					
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	110.40 (96.80)	T		B
8342	Amalgam - two surfaces	04.00	136.10 (119.40)	T		B
8343	Amalgam - three surfaces	04.00	165.90 (145.50)	T		B
8344	Amalgam - four or more surfaces	04.00	184.70 (162.00)	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/composomers 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	240.70 (211.10)	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	133.50 (117.10)	T		B
8352	Resin - two surfaces, anterior	04.00	167.90 (147.30)	T		B

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8353	Resin - three surfaces, anterior	04.00	200.60 (176.00)	T		B
8354	Resin - four or more surfaces, anterior	06.03	223.90 (196.40)	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	144.80 (127.00)	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	179.10 (157.10)	T		B
8369	Resin - three surfaces, posterior	04.00	216.30 (189.70)	T		B
8370	Resin - four or more surfaces, posterior	04.00	232.70 (204.10)	T		B
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
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
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.					
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
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
OTHER RESTORATIVE PROCEDURES						
Unclassified Restorative Procedures						
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.					
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
8303	Pulp cap - indirect	06.03	76.50 (67.10)	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.					

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
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
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
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
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
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
DENTURE REBASE PROCEDURES						
	Rebase – The partial or complete removal and replacement of the denture base.					06.03
DENTURE RELINE PROCEDURES						
	Reline - The addition of material to the fitting surface of a denture base.					06.03
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
OTHER REMOVABLE PROSTHETIC PROCEDURES						
8277	Inlay in denture	06.03			+L	A
	Limitation: Benefits by arrangement.					
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 Where “+D” appears the practitioner will charge the relevant fee/benefit for the denture in the Schedule plus the fee/benefit indicated					06.03
EXTRA-ORAL APPLIANCES						
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				
9152	Extraoral appliance - additional prosthesis	04.00			+L	
9153	Extraoral appliance - replacement prosthesis	04.00			+L	
TRISMUS APPLIANCES						
9173	Hand splint	05.02			+L	
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
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

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				
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 overlayed to be considered an onlay. See inlay/onlay restorations in the Restorative Services Section for inlay/onlay retainers.	06.03				
BRIDGE RETAINERS – CROWNS						
	A crown retainer for a bridge that gains retention, support and stability from a tooth.	06.03				
OTHER FIXED PROSTHODONTIC PROCEDURES						
	See "other restorative services" for procedures related to fixed prosthesis not listed in this sub-section.	06.03				
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	60.30 (52.90)	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	23.30 (20.40)	T		B
	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				
VESTIBULOPLASTY						
	Any of a series of surgical procedures designed to increase relative alveolar ridge height.	06.03				
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS						
9290	Maxillectomy - Alveolus only, Level I	06.03				
	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.					
SURGICAL INCISION						
9011	Incision & drainage of abscess - intra-oral (pyogenic)	05.02	74.30 (65.20)	M		S
TREATMENT OF FRACTURES						
Nasal Fractures						
9280	Open reduction and fixation of nasal fractures	04.00				
9282	Manipulation and immobilisation of nasal fracture	04.00				
TEMPOROMANDIBULAR JOINT						
	Procedures which are an integral part of a primary procedure should not be reported separately.	06.03				
COMPLICATED SUTURING						
	Reconstruction requiring delicate handling of tissues and undermining for meticulous closure. Excludes the closure of surgical incisions.	06.03				

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OTHER REPAIR PROCEDURES						
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				
Functional Correction of Malocclusion						
	For Codes 9047 to 9072 the full fee may be charged.					06.03
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				
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 trusting).					06.03
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
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
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
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
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
L. SUPPLEMENTARY SERVICES						
	The branch of dentistry for unclassified treatment including palliative care and anaesthesia.					06.03
ANAESTHESIA						
8145	Local anaesthetic - per visit 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.	06.03	9.16 (8.04)			B
PROFESSIONAL VISITS						
8129	Office/hospital visit – after regularly scheduled hours Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to appropriate code numbers for actual services rendered. After regularly scheduled hours is definend as weekends and night visits between 18h00 and 07h00 the following day. Limitation: Code 8129 may only be reported for emergency treatment rendered outside normal working hours. Not applicable where a practice offers an extended hours service as the norm.	06.03	129.30 (113.40)			B

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8140	House/extended care facility/hospital call	06.03	85.50 (75.00)			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.					
DRUGS, MEDICAMENTS AND MATERIALS						
8109	Infection control/barrier techniques	06.03	9.32 (8.18)			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.					
8220	Cost of suture material	06.03	-			B
	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.					
ADMINISTRATIVE AND LABORATORY SERVICES						
8111	Dental testimony	06.03				
	Use to report dento-legal fees when the practitioner is present at Court at the request of an advocate or attorney. Report per hour.					
8120	Treatment plan completed	06.03	-			
	Use to report the completion of a treatment plan effected from an oral evaluation – See Rule 008.					
8139	Appointment not kept /30min	06.03	-			B
	Comment: By arrangement with patient					
MISCELLANEOUS SERVICES						
Palliative Treatment						
8131	Emergency dental treatment	06.03	53.90 (47.30)	T		B
	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).					
8166	Application of desensitising resin, per tooth	06.03	35.60 (31.20)	T		B
	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.					
8167	Application of desensitising medicament, per visit	06.03	41.40 (36.30)			B
	This procedure involves the application of topical fluoride on teeth and/or root surfaces and should not to 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	53.90 (47.30)	T	+L	B
	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	39.30 (34.50)			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.					
8935	Treatment of septic socket	06.03	39.30 (34.50)			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

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	See code 8310 in the section 'Adjunctive general services' for materials supplied Limitation: Benefits by arrangement.					
8311	Home bleaching - subsequent visit Limitation: A maximum of three additional visits may be charged. Benefits by arrangement.	06.03				A
Unclassified Treatment						
8168	Behavior management 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.	06.03				B
MODIFIERS						
8001	Assistant surgeon - specialist (1/3 of the appropriate benefit)					06.03
8002	Specialist fee/benefit (Plus 50% of the appropriate benefit)					06.03
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