

Dental Therapy 2007

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY DENTAL THERAPISTS EFFECTIVE FROM 1 JANUARY 2007								
I.	INTRODUCTION							
	<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 procedure 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>							
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						
	<ul style="list-style-type: none"> 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 oral health care provider 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. 	07.00						
	Note: Photocopies of original invoices shall be certified by way of a rubber stamp or the signature of the oral health care provider.	07.00						
002	Cost of medicine and direct materials:	07.00						
	<p>Expenses incurred for the dispensing of medicine and for the use of direct materials may be charged in addition to the appropriate procedure code. These expenses are limited to the cost of the medicine/materials and an administration fee.</p> <p>Report the appropriate direct material code, followed by the administration fee code applicable to the material. Administration fees are submitted by reporting code 8090 for medicine dispensed by a licensed dispensing dental practitioner; code 8091 for medicine used during a dental visit; and code 8092 for dental direct materials.</p> <p>Example for reporting the cost of medicine/direct material and administration fee:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;">8560</td> <td style="width: 60%;">Cost of ceramic block</td> <td style="width: 30%; text-align: right;">R 100.00</td> </tr> <tr> <td>8092</td> <td>Admin fee (direct material)</td> <td style="text-align: right;">R 26.00</td> </tr> </table>	8560	Cost of ceramic block	R 100.00	8092	Admin fee (direct material)	R 26.00	07.00
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003	Dental laboratory services:	05.02						
	Dental laboratory fees may be charged by the oral health care provider (using code 8099) on receipt of the invoice from the technician. If the patient does not return for completion of treatment, the oral health care provider is still entitled to present a laboratory invoice to the patient for payment.	07.00						
	<p>Manual submission of invoices. Fees charged by dental technicians for laboratory services (PLU SL) shall be indicated on the oral health care provider's invoice by reporting code 8099 - Dental laboratory service with the appropriate laboratory fee on the line following the relevant dental procedure code.</p> <p>The technician's invoice shall be certified by the oral health care provider (or a person appointed by the provider) for correctness by means of a signature. The original invoice of the dental technician (or a copy thereof) shall accompany the invoice of the provider and a copy (or the original) shall be filed by the provider for record purposes.</p>	07.00						
	<p>Electronic submission of invoices. Fees charged by dental technicians for laboratory services (PLU SL) shall be indicated on the oral health care provider'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.</p> <p>The technician's invoice shall be certified by the provider (or a person appointed by the provider) for correctness by means of a signature. The original invoice of the dental technician shall be filed by the provider for record purposes.</p>	07.00						

Code	Description	Ver	Dental Therapy	M P	Lab	T C
	Example: 8401 Crown - full cast metal (Dental practitioner's reference price) 8099 Dental laboratory service (Dental technician's fee) 9521 Dental technician's service code(s) (Dental technician's fee) Etc. (Dental technician's fee)					07.00
005	Procedure accompanied by unusual circumstances: In exceptional cases where the proposed reference price is disproportionately low in relation to the actual services rendered by a practitioner, such higher fees 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.					07.00
B.	General coding rules					
006	Dental procedures not listed for a specific provider category.					07.00
	The schedule does not prescribe the scope of practice of a particular category of Oral Health Care Provider. Reference prices listed within a column of a particular category of Oral Health Care Provider are those prices to be used by a service provider in that category.					07.00
007	Procedures not listed in the Dental Schedule					05.02
	Unlisted procedures. Any procedure that is neither described in the Dental Schedule, should be reported using code 9099 - Unlisted dental procedure or service. The reference price for an unlisted dental procedure or service should be based on the reference price of a comparable procedure. Code 9099 should not be used to report procedures where the reference price is determined "by arrangement" with the patient and/or medical scheme. Please contact the SA Dental Association (SADA) Private Practice Committee via e-mail on coding@sada.co.za to obtain a comparable code for the unlisted procedure or service which will be based on the reference price for a comparable service in the coding structure. When code 9099 is used to indicate that an unlisted service was rendered, the use of the code must be supported by a special report. This report must include: (1) An adequate definition or description of the nature, extent and need for the procedure/service or "medical necessity"; (2) In which respect is this service unusual or different in technique, compared to available procedures/services listed in the coding structure? Information regarding the nature and extent of the procedure/service, time and effort, special/dedicated equipment needed to provide this service, must be included in the report; (3) Is this procedure/service medically appropriate under the circumstances? Explain why another procedure/service listed in the coding structure will not be appropriate in this case; (4) A description of the complexity of the symptoms and concurrent problems must be supplied; (5) Final diagnosis supported by the appropriate ICD-10 code(s); (6) Pertinent physical findings (size, location and number of lesions if applicable); (7) Mention any other diagnostic or therapeutic procedure(s)/service(s) provided at the same session; (8) Any further diagnostic or therapeutic procedure(s)/service(s) to be provided in the follow-up period; and (9) Description of the follow-up care needed. Please note: This comparable service code may not be used for a period longer than six months for a particular procedure/service after which time an application has to be made for the addition of a specific code for this procedure.					07.00
C.	Services rules					
008	Oral evaluations and completion of treatment plans:					07.00
	Oral examinations include an examination, diagnosis and treatment planning (when treatment is required). No further fees shall be levied for an oral examination (code 8101) or comprehensive examination (code 8102) until the treatment plan resulting from these types 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 oral health care provider 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 provider. Treatment plan defined. The treatment plan is the sequential guide for the patient's care as determined by the oral health care provider's diagnosis and is used by the provider for the restoration and/or maintenance of optimal oral health					07.00
009	Surgery guidelines:					05.02
	1. Follow-up care for therapeutic surgical procedures: The reference price for an operation shall, unless otherwise stated, include normal post-operative care for a period not less than one month. If a practitioner does not him/herself complete the post-operative care, he/she shall arrange for post-operative care without additional charges. A reference price for post-operative treatment of a prolonged or specialised nature may be charged as agreed upon between the practitioner and the scheme.					07.00
011	Dento-legal fees:					07.00
	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.					07.00
D.	Modifiers					
012	Modifiers:					07.00

Code	Description	Ver	Dental Therapy	M P	Lab	T C
	<p>Modifiers should be used with procedures as indicated.</p> <p>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:</p> <ol style="list-style-type: none"> A service or procedure was performed by more than one practitioner. A service or procedure has been increased or reduced. Only part of a service was performed. An adjunctive service was performed. A service or procedure was provided more than once. The reference price was altered due to a financial agreement. 					07.00
8006	Multiple surgical procedures – third and subsequent procedures					07.00
	50% of the appropriate reference price. See Modifier 8009.					
8008	Emergency surgery – after hours					07.00
	PLUS 25% of the appropriate reference price. When emergency surgery is performed after hours, such surgical procedures can be identified by adding Modifier 8008 to the procedure codes by each participating member of the surgical team.					
8009	Multiple surgical procedures – second procedure					07.00
	75% of the appropriate reference price. When multiple procedures (under the same anaesthetic but through another 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 additional procedures should be identified by adding the appropriate modifier (M 8009 or M 8006) to the additional procedure codes.					
8011	Procedure accompanied by unusual circumstances					07.00
	Reference price PLUS X % as determined by the practitioner and agreed upon by patient/medical scheme. When the service provided by a practitioner is greater than that is usually required for the listed procedure, it may be identified by adding Modifier 8011 to the usual procedure code.					
8012	Reduced services					07.00
	Reference price MINUS X % as determined by the practitioner. Under certain circumstances a service or procedure is partially reduced or eliminated at the practitioner's election. Under these circumstances the service provided can be identified by its usual procedure code and the addition of Modifier 8012, signifying the service is reduced.					
8013	Multiple modifiers					06.03
	Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations Modifier 8013 should be added to the basic procedure and the other applicable modifiers may be listed as part of the description of the service.					
E.	Explanations					
Tooth identification and designation of areas of the oral cavity.						
	<p>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.</p>					04.00
Treatment categories:						
	<p>Treatment categories (TC) of dental procedures are identified in the TC column of the Dental Coding as follows:</p> <p>Basic dentistry - designated as (B) in the treatment category column</p> <p>Advanced dentistry - designated as (A) in the treatment category column</p> <p>Surgery - designated as (S) in the treatment category column</p>					07.00
Abbreviations used in Dental Coding						
	<p>DM Direct Material Column</p> <p>+D Add fee/benefit for denture</p> <p>+L Add laboratory fee</p> <p>+M Add material fee</p>					05.02
	<p>MP Mouth Part Column</p> <p>M Maxilla/Mandible</p> <p>Q Quadrant</p> <p>S Sextant</p> <p>T Tooth</p>					05.02
	<p>TC Treatment Category Column</p> <p>A Advanced dentistry</p> <p>B Basic dentistry</p> <p>S Surgery</p>					05.02
	<p>Practice type codes:</p> <p>25400 General Dental Practitioner</p> <p>26200 Specialist Maxillo Facial and Oral Surgeon</p> <p>26400 Specialist Orthodontist</p> <p>29200 Specialist in Oral Medicine and Periodontics</p> <p>29400 Specialist Prosthodontist</p> <p>29800 Specialist Oral Pathologist</p> <p>39500 Dental Therapist</p>					06.03

Code	Description	Ver	Dental Therapy	M P	Lab	T C
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. It is recommended that medical schemes, where considered necessary and appropriate, state contract limitations on the frequency of providing care for certain services be as "twice a calendar year" rather than once in every six months.					07.00
	Radiographs and records. Radiographs should be taken only for clinical reasons as determined by the treating therapist. Postoperative radiographs should only be required as part of dental treatment. When a therapist 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 therapist. Any additional costs incurred by the therapist in copying radiographs and clinical records for claims determination should be reimbursed by the third-party payer or the patient.					07.00
	New vs. established patient. A new patient is one who has not received any professional services from the therapist or another therapist 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 therapist or another therapist who belongs to the same group practice, within the past three years. In the instance where a therapist is on call for or covering for another therapist, the patient's encounter will be classified as it would have been by the therapist who is not available.					07.00
II ITEMS						
1. 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
1.1 Clinical oral evaluations						
	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
Code	Description	Ver	Dental Therapy	M P	Lab	T C
8101	Oral examination	07.00	56.30 (49.40)			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 charged until the treatment plan resulting from this assessment is completed (See Rule 008).					
8102	Comprehensive oral examination	07.00	91.00 (79.80)			B
	An assessment performed on a new or established patient (patient of record) to determine the patient's dental and medical health status involving a comprehensive examination, diagnosis and treatment plan. It is a thorough assessment and recording of the patient's past and current state of oral health (extraoral and intraoral hard and soft tissues), risk for future dental disease as well as assessing general health factors that relate to the treatment of the patient. A comprehensive examination 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 Temporomandibular Joint). The patient shall be provided with a written comprehensive treatment plan, which is a part of the patient's clinical record and the original should be retained by the dentist. No further oral examination fees shall be levied until the treatment plan resulting from this assessment is completed (See Rule 008).					
8104	Limited oral examination	07.00	43.90 (38.50)			B

Code	Description	Ver	Dental Therapy	M P	Lab	T C
	An assessment performed on a patient 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. 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. This code is also reported when a patient is referred to a specialist who performs a limited examination, diagnosis and presentation of an estimated treatment plan to enable the patient to make a decision as to future treatment. Code 8104 may not be reported together with any other clinical examination on the same day. A limited oral examination is usually followed by a thorough assessment to determine the patient's oral and medical health status to arrive at a complete treatment plan.					
8189	Re-examination – existing condition	07.00	43.90 (38.50)			B
	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. 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; (3) with soft tissue lesions such as a leukoplaki observed on a previous visit that require follow-up monitoring of pathological changes. A re-examination is not a post-operative visit.					
8176	Periodontal examination (screening)	07.00	47.40 (41.60)			B
	Periodontal examinations 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. This code should not be used concurrent with any other oral examination codes.					
1.2	Professional visits					
8129	Office/hospital visit – after regularly scheduled hours	07.00	135.10 (118.50)			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. 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	07.00	89.30 (78.30)			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. Subsequent visits: Where a procedure or operation was done, subsequent house/extended care facility/hospital calls are regarded as part of the normal after-care and no fees may be levied (unless otherwise indicated). Where no procedure or operation was carried out, code 8140 may be charged in addition to the appropriate code numbers for actual services performed.					
1.3	Radiographs/Diagnostic imaging					
	Diagnostic radiographs/diagnostic images include interpretation. Radiographs/diagnostic images should only be taken for clinical reasons as determined by the practitioner 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 practitioner 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.					07.00
8107	Intraoral radiograph – periapical	07.00	42.20 (37.00)			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	07.00	338.90 (297.30)			B
	A complete series consists of a minimum of eight intraoral radiographs, periapical and or bitewing, occlusal radiographs excluded.					
8112	Intraoral radiograph – bitewing	07.00	42.20 (37.00)			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.					

Code	Description	Ver	Dental Therapy	M	Lab	T	C
8113	Intraoral radiograph – occlusal	07.00	72.50 (63.60)				B
8115	Panoramic radiograph	07.00	168.90 (148.20)				B
8116	Cephalometric radiograph	07.00	168.90 (148.20)				B
8121	Oral and/or facial image (digital/conventional)	06.03	45.20 (39.60)				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.						
1.4	Other diagnostic procedures						
8117	Diagnostic models	06.03	45.20 (39.60)		+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	07.00	113.80 (99.80)		+L		B
	See code 8117 for descriptor. Report this code when models are mounted on a semi-adjustable articulator.						
8123	Caries susceptibility tests	07.00	47.00 (41.20)				B
	A caries susceptibility test is a diagnostic test for determining the pH of a patient's saliva to evaluate the patient's propensity for caries. This code should not be used for a caries detection test (cariou dentine staining), which is performed to determine if all the caries has been removed. A caries risk assessment report must be made available 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	Occlusal analysis on adjustable articulator	07.00	141.90 (124.50)				A
2.	Preventive Services						
	Services/procedures intended to eliminate or reduce the need for future dental treatment.						06.03
2.1	Dental prophylaxis						
8155	Polishing – complete dentition	07.00	54.00 (47.40)				B
	Polishing involves the removal of stains and bacterial plaque (biofilm) from the clinical crowns of natural teeth, and making the surface smooth and glossy; helps to reduce dental caries, marginal gingivitis, and improves appearance of the teeth. Includes the complete primary, transitional or permanent dentition. This code may not be used concurrently with codes 8159, 8737 or 8739. See code 8157 in the restorative section for the re-burnishing and polishing of restorations.						
8159	Prophylaxis (scaling and polishing) – complete dentition	07.00	98.40 (86.30)				B
	Prophylaxis (scaling and polishing) involves a series of procedures for the removal of calculus, bacterial plaque (biofilm), stain, and other accretions from the clinical crowns of all the teeth. Includes the complete primary, transitional or permanent dentition. This code may not be used concurrently with codes 8155, 8737 or 8739. See code 8157 in the restorative section for the re-burnishing and polishing of restorations.						
2.2	Topical fluoride treatment (office procedure)						
	Topical fluoride treatment procedures involve the professional 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	07.00	54.00 (47.40)				B
	To be used for treatment of complete dentition to prevent dental caries. In this context a child is defined as a person of 11 years of age or younger. Report code 8167 in the miscellaneous section when fluoride is used as a desensitising medicament. Code 8161 may not be used concurrently with code 8167.						
8162	Topical application of fluoride – adult	07.00	54.00 (47.40)				B
	See code 8161 for descriptor. In this context an adult is defined as a person of 12 years of age or older.						
2.3	Space maintenance (passive appliances)						
	Passive appliances are designed to prevent tooth movement.						06.03
8173	Space maintainer – fixed	07.00	100.20 (87.90)	M	+L		B

Code	Description	Ver	Dental Therapy	M	Lab	T	C
8174	Recementation of space maintainer	07.00	54.00 (47.40)				B
8175	Space maintainer – removable	07.00	129.20 (113.30)	M	+L		B
2.4	Other preventive services						
8151	Oral hygiene education and plaque control instruction	07.00	44.20 (38.80)				B
	The dental knowledge of the patient/parent to prevent oral diseases should be evaluated or appropriate education be provided before oral hygiene instruction is provided i.e. information about bacterial plaques (dental biofilm) in relation to dental caries and periodontal disease, how dental caries progresses to involve pulp, and periapical bone, and how dental caries and periodontal disease can ultimately lead to loss of teeth and other more severe complications. Information should also be provided about fluoride, how it works to prevent dental caries, how it is used preventively, and information about dental sealant should be provided when appropriate. The patient must be informed prior to the service of oral hygiene education and bacterial plaque (dental biofilm) control instruction being rendered that a fee will be levied for this code. If the service is provided for a child, it should take place in the presence of a parent and/or guardian.						
8153	Oral hygiene education and plaque control instruction – each additional visit	07.00	32.30 (28.30)				B
	Use code 8153 when additional oral hygiene education and plaque control instruction are required during the course of a treatment plan. No other preventive services may be reported at the same visit. See code 8151.						
8149	Nutritional counselling	07.00	54.00 (47.40)				B
	Requires a broad analysis of dietary habits and food selection, provision of advice and guidance to the patient and where appropriate (eg in the case of a child) to the patient's family and siblings, on the rôle of diet, nutrition, and specifically on the importance of certain dietary selections in the context of the prevention and control of dental decay and periodontal diseases. Comment: (1) The need for nutritional counselling must be established by caries and/or periodontal disease risk assessment (See also codes 8122 and 8123). (2) A dietary habit analysis and food selection programme must be made available at no additional charge, on request or if deemed necessary. (3) Certain funders do not provide benefits for nutritional counselling for the control of dental disease.						
8150	Tobacco counselling	07.00	54.00 (47.40)				B
	Requires the provision of advice, guidance and support-services to the tobacco-using patient on stopping such use to prevent and control the development of tobacco-related oral diseases and conditions, incidentally to control or prevent a whole range of systemic diseases and disorders, and to improve the prognosis for certain dental, periodontal, or al medical and oral surgical treatments. Comment: (1) The need for tobacco counselling must be established from the patient's history and/or by oral examination and risk assessment. If requested, or if deemed necessary a tobacco prevention and cessation programme and direction to appropriate tobacco-control services must be made available at no additional charge. (2) The services intended in code 8150 should be reserved for those persons who are not able to give up the use of tobacco after simple advice to do so by a specific mutually agreed and recorded date. (3) Formal tobacco counselling (code 8150) is limited to 10 services. (4) Certain funders do not provide benefits for tobacco cessation treatment interventions.						
8163	Sealant – per tooth	07.00	40.00 (35.10)	T			B
	Also known as pit-and fissure sealant. Fissure sealing involves the mechanical and/or chemical preparation of an occlusal enamel surface and placement of a material to seal the caries-prone pits, fissures, and grooves of a tooth. A preventive resin restoration is distinguished from a sealant in that in the former the caries penetrates into dentin. If the caries is limited to the enamel, it is still considered a sealant.						
3.	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. For reporting purposes 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. A four-or-more-surface anterior restoration involves four tooth surfaces and the incisal angle. 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 their 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.						07.00
3.1	Amalgam restorations (including polishing)						
	All adhesives, liners, bases and polishing are included as part of the restoration.						07.00
8341	Amalgam – one surface	07.00	115.40 (101.20)	T			B
8342	Amalgam – two surfaces	07.00	142.20 (124.70)	T			B
8343	Amalgam – three surfaces	07.00	173.40 (152.10)	T			B

Code	Description	Ver	Dental Therapy	M	Lab	T	C
8344	Amalgam – four or more surfaces	07.00	193.00 (169.30)	T			B
3.2	Resin-based composite restorations						
	Resin restorations refer to a broad category of materials including but not limited to composites and glass ionomers/composers. The procedures include acid etching, adhesives (including resin bonding agents) and curing part of the restoration. Resin restorations utilise the direct technique.						07.00
8350	Resin crown – anterior primary tooth (direct)	07.00	251.50 (220.60)	T			B
	This procedure involves the full coverage of an anterior primary tooth with a resin-based material.						
8351	Resin – one surface, anterior	07.00	139.50 (122.40)	T			B
8352	Resin – two surfaces, anterior	07.00	175.40 (153.90)	T			B
8353	Resin – three surfaces, anterior	07.00	209.60 (183.90)	T			B
8354	Resin – four or more surfaces, anterior	07.00	234.00 (205.30)	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 – two surfaces, posterior	07.00	151.30 (132.70)	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	07.00	187.10 (164.10)	T			B
8369	Resin – three surfaces, posterior	07.00	226.00 (198.20)	T			B
8370	Resin – four or more surfaces, posterior	07.00	243.20 (213.30)	T			B
4.	Endodontic Services						
	Services/procedures intended to treat diseases of the dental pulp and their sequelae.						06.03
4.1	Pulp capping						
	These codes should not be used as a base or liner under a restoration.						07.00
8301	Pulp cap – direct	07.00	79.90 (70.10)	T	+M		B
	This procedure involves the covering of the exposed dental pulp with a protective material (e.g. calcium hydroxide or MTA) to stimulate repair of the injured pulpal tissue. Excludes the final restoration. See Rule 002 and Appendix A for the cost of direct materials.						
8303	Pulp cap – indirect	07.00	79.90 (70.10)	T			B
	This procedure involves the placement of a medicament to protect the pulp from external irritants and to stimulate secondary dentine formation when the pulp is not directly exposed. Excludes the final restoration that should not be placed within 6 weeks, except when Ozone in combination with glass ionomer is used.						
5.	Oral and Maxillofacial Surgery						
	The branch of dentistry using surgery to treat disorders/diseases of the mouth. Surgical procedures include routine postoperative care.						06.03
5.1	Extractions						
8201	Extraction of tooth or exposed tooth roots – first tooth per quadrant	07.00	63.00 (55.30)	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 of tooth or exposed tooth roots – each additional tooth per quadrant	07.00	24.30 (21.30)	T			B
	To be reported for an additional extraction in the same quadrant at the same visit.						
5.2	Surgical incision						
9011	Incision and drainage of abscess – intra-oral (pyogenic)	07.00	77.60 (68.10)	M			S
5.3	Post surgical complications						
8931	Treatment of local haemorrhage	07.00	41.10 (36.10)	M			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.						

Code	Description	Ver	Dental Therapy	M	Lab	T	C
8935	Treatment of septic socket(s)	07.00	41.10 (36.10)	M			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.						
6.	Supplementary Services						
	The branch of dentistry for unclassified treatment including palliative care and anaesthesia.						06.03
6.1	Anaesthesia						
8145	Local anaesthesia	07.00	9.57 (8.39)				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.						
6.2	Drugs, medicaments and materials, equipment, administrative and laboratory services						
6.2.1	Drugs, medicaments and materials						
	See Rule 002 and Appendix A for guidelines with regard to dispensing of medicine, once-off administration fee of medicine used during a dental visit and administration fee for dental direct materials.						07.00
8109	Infection control/barrier techniques	07.00	9.73 (8.54)				B
	Reported "per visit" for new rubber gloves, masks, etc. used by the dentist, oral hygienist, dental assistant or dental therapist.						
8110	Sterilized instrumentation	07.00	25.10 (22.00)				B
	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.						
6.2.2	Administrative and laboratory services						
8106	Special report	07.00	94.20 (82.60)				B
	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.						
8111	Dental testimony	07.00	-				
	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	07.00	-				
	Use to report the completion of a treatment plan affected from an oral examination – See Rule 008.						
8139	Appointment not kept – per half-hour	07.00	-				B
	Comment: Fee by arrangement with patient.						
6.3	Miscellaneous services						
6.3.1	Palliative treatment						
8131	Emergency dental treatment	06.03	56.30 (49.40)	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 exist and may not be reported with other procedure codes (diagnostic procedures and professional visits excluded).						
8165	Sedative filling	07.00	56.30 (49.40)	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.						
8166	Application of desensitising resin, per tooth	06.03	37.20 (32.60)	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	43.30 (38.00)				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.						
6.3.2	Unclassified treatment						
8168	Behaviour management	07.00	-				B

Code	Description	Ver	Dental Therapy	M P	Lab	T C
	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.					
9099	Unlisted dental procedure or service	07.00	-			
	The intention of this code is to report a dental procedure or service which is not adequately described by a code. Describe procedure. See Rule 007.					
7.	Other codes					
7.1	Modifiers					
7.2	Administration of medicine and direct materials					
7.3	Dental direct materials					
	The following direct dental materials may, when provided by the practitioner, be billed by reporting the appropriate material code, followed by code 8092 – See Rule 002.					07.00
8220	Cost of suture material	07.00	-			B
	Use in conjunction with procedure(s) when suture material is provided by the practitioner. Report per pack					
8306	Cost of mineral trioxide aggregate (MTA)	07.00	-			B
	Current applications include: Apical plug during apexification; Repair of root perforations during root canal therapy; Treating internal root resorption; Root-end filling material; Pulp-capping material. See codes 8301, 8331, 8634, 8635, 8636, 8637, 8638, 8641 and 8642.					