

Code 9201 has only been used 21 times and code 9205 three times by pathologists during 2005.

Diagnostic Services – Professional visits

There are currently eight types of professional visits that have been reduced to two. The rules that apply to these visits have also been standardised among the different types of oral health care providers.

Diagnostic Services – Other Diagnostic Procedures

Code 8122 (Microbiological studies) is currently “zero-rated”. The allocation of a UV to this procedure will await a comprehensive submission of item times.

There are no other additions, revisions or deletions submitted within the diagnostic service section.

Preventive Services

Code 8160 (Removal of gross calculus) is currently “zero-rated”. The proposed rate is equal to current code 8155 (Polishing of complete dentition) which should more or less take the same time to perform as the code 8155. We could not find a similar code in other international schedules for the purpose of benchmarking. This code has been reported 143 times during 2005 and 36 times during 2006 (database provided). This code should be deleted from the NHRPL to prevent abuse.

Code 8174 (Re-cement space maintainer) was added to improve accurate reporting and electronic record keeping. Code 8133 (Recement inlay/onlay/crown) is currently used to report this procedure. The proposed rate is the same as that of code 8133 – no financial implications.

Codes 8149 (Nutritional counselling) and 8150 (Tobacco counselling) are currently “zero-rated”. Code 8149 had been reported twice and code 9150 once during 2005. The low utilisation is most probable due the fact that the codes are zero-rated. The rates proposed are equal to the current code 8151 (Oral hygiene instruction). Several USA based funders provide higher benefits for codes 8149 and 8150 than code 8151. Both these services are regarded as essential primary oral health prevention strategies and are supported in evidence-based literature. The conservative approach given the lack of proper UV studies is supported. SA based funders should determine if they would like to include these service as part of their covered benefits.

Codes 8177 and 8178 (Oral hygiene instruction for the periodontally compromised patient) have been deleted and are replaced by current codes 8151 and 8153 with reduced rates. The deletion of these codes is supported because they are abused and the difference in rates cannot be substantiated.

Codes 8179 (Polishing perio compr) and 8180 (Prophylaxis perio compr) are currently only listed in the GDPs schedule. The codes though, were also reported by periodontists (Code 8179 x 171 and code 8180 x1571 during 2005). The reason for this is unclear because the periodontist rates for codes 8155 and 8159 are higher (R87.60 and R176.10) than that of the GP rates for code 8179 and 8180 (R63.60 and R124.90). Code 8179 and 8180 could not be benchmarked against other international schedules and are open for abuse and deletion from the schedule is recommended.

One should also take note of new code 8740 (Periodontal maintenance), which is listed in the periodic services section. The rate proposed for this code is similar to that of code 8180, which is supported because the service rendered is the same as code 8180. Code 8740 can be managed to prevent abuse.

Restorative Services

Codes 8561, 8653; 8565 (Gold foil restorations) nomenclatures were revised– no financial implications.

CAD-CAM Technique. When a CAD-CAM technique is used, the dental practitioner manufactures the final restoration within the surgery and it is not outsourced to a dental laboratory. In most of these instances interim (temporary) restorations are not required. Since the cost to manufacture interim restorations are current considered as being part of the final restorations, it has become necessary to deduct the cost of the interim restorations from that of the definite restoration to prevent the billing for services (the interim/temporary restoration) not rendered. This argument is also true in instances where practitioner make use of a dental laboratory to manufacture the interim restorations.

Codes for interim in/onlays, crowns (tooth and implant supported), retainers (tooth and implant supported), and pontics were introduced to address this issue (8360, 8400, 8541, 8542, 8571, 8572, 8421, 8431 and 8440). The initial rates proposed for these interim restorations are deducted from the rates of the definite restorations to ensure a financial neutral implementation of these codes – no financial implications.

Code 8570 is currently being used for the manufacturing of CAD-CAM restorations with one surface up to a full crown. The nomenclature of code 8570 has been revised to include restoration consisting of four and more surfaces and a new code 8569 proposed to include one to three surfaces. This will facilitate future UV development. The rates proposed are equal to that of 8570, which is currently being charged – no financial implication.

Code 8406 (Crown 3/4 resin) was added for accurate reporting. Currently any other crown procedure can be used and the rate proposed is the same as that of other crowns – no financial implication.

Code 8348 (Tooth pin retention additional pin) was deleted for accurate reporting and future UV development. Current code 8347 (Tooth pin retention) has to be reported. This will have a slight increase in benefits as a result (R58.20 to R62.80), a difference of

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R4.60 (+7.9%). This is line with international practise and there is no difference in time to provide additional pins. The utilisation for code 8348 during 2005 was 13,516 (Database provided).

Code 8396 (Coping – metal, single) was added for accurate reporting and future UV development. Code 8587 (Revised to read Coping – metal w/ bridges) is currently used to report the service. Rate of code 8587 is proposed – no financial implication.

Codes 8581/2/3 (Cast post and cores) used by prosthodontists have been deleted because it is a duplicate. GP codes 8397 and 8398 to be used – no financial implication.

Code 8130 (Rebond veneer) was added for accurate reporting and future UV development. Code 8133 (Recement inlay/onlay/crown) is currently used to bill the service. Rate of code 8133 is proposed – no financial implication.

Code 8134 (Recement cast core or post) was added for accurate reporting and future UV development. Code 8133 (Recement inlay/onlay/crown) is currently used to bill the service. Rate (GP) of code 8133 is proposed – no financial implication.

Code 8146 (Resin bonding for restoration) is currently “zero-rated”. No UV was proposed. We could not find a similar code in other international schedules for the purpose of benchmarking. The costs for the cementation/bonding of restorations are included as part of the final restoration. This code was initially added due to the cost of the bonding material. Since the bonding material cannot be classified as a direct material, the cost should be covered by overheads. The proposal is that the code should remain “zero-rated” and be deleted when proper UVs and RVUs are introduced.

Endodontic Services

Root canal treatment (RCT) on primary teeth. The addition of code 8312 (RCT primary anterior) and 8313 (RCT primary posterior) allows accurate reporting and future UV development. Currently, any of the appropriate codes for root canal treatment on permanent teeth are used to report and bill these services. The reduced rates proposed are more or less the same as being used in the USA – 30 to 50% reduction in rates.

Root canal treatment (RCT) on permanent teeth. There are currently three “options” of codes that are used for the reporting and billing of RCT.

- Option 1 - Codes used when the treatment is not completed during the same visit. Three codes for preparatory visits (with differentiation between single and multiple canals) and four codes for the obturation of the root canals (with differentiation between anterior/premolars/molars first and additional canals) are used. The current rates exclude the use of intra-operative intra-oral radiographs. The preparatory visits are limited to four per tooth to prevent abuse.
- Option 2 - Codes used when the treatment is completed during the same visit. Four codes are used (with differentiation between anterior/premolars/molars

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first and additional canals). The current rates exclude the use of intra-operative intra-oral radiographs.

- Option 3 - Codes used by prosthodontist. Two codes are used (with differentiation between first and second canals). The current rates include the use of intra-operative intra-oral radiographs.

The new sets of codes make provision for the preparatory of the canals per canal, the obturation of the canals per canal and irrigation and medication visits (the latter only if separate visits are required). Differentiation is made between the first canal per tooth and between additional anteriors/premolars and molars. This approach prevents abuse of an increasing number of visits and improves standardisation, accurate reporting and cost determination.

Table 5 : Root Canal Treatments

ROOT CANAL PREPARATION				Anterior/Premolars		Molars	
				1 Canal	2 Canals	3 Canals	4 Canals
8315	RC prep first canal	294.3		294.30	294.30	294.30	294.30
8316	RC prep ant/prem - ea addnl	98.3			98.30		
8317	RC prep molar - ea addnl	153.3	110.00			306.60	459.90
8318	RC irrigation/medication visit	63.6					
ROOT CANAL OBTURATION							
8319	RC obturation first canal	147.1		147.10	147.10	147.10	147.10
8320	RC obturation ant/prem ea addl	49.1			49.10		
8321	RC obturation molar ea addnl	76.7	55.10			153.40	230.10
				441.40	588.80	901.40	1 131.40
PREPARATORY VISITS							
8332	RC prep visit - single canal	63.6		63.60			
8333	RC prep visit - multi canal	89.2			89.20	89.20	89.20
OBTURATION OF CANALS							
8335	RC obt ant/prem 1st canal	288.6		288.60	288.60		
8328	RC obt ant/prem ea addnl	118			118.00		
8336	RC obt post 1st canal	397.2				397.20	397.20
8337	RC obt post ea addnl	118				236.00	354.00
Obturation Totals:				288.60	406.60	633.20	751.20
1 Prep Visit Totals:				352.20	495.80	722.40	840.40
2 Prep Visit Totals:				415.80	585.00	811.60	929.60
3 Prep Visit Totals:				479.40	674.20	900.80	1 018.80
4 Prep Visit Totals:				543.00	763.40	990.00	1 108.00
COMPLETE THERAPY							
8338	RC therapy ant/prem 1st canal	441.4		441.40	441.40		
8329	RC therapy ant/prem ea addnl	147.4			147.40		
8339	RC therapy post 1st canal	606.6				606.60	606.60
8340	RC therapy post ea addnl	147.4				294.80	442.20
				441.40	588.80	901.40	1 048.80

The proposed rates for the new preparatory codes (8315/6/7) and obturation codes (8319 and 8320/1) are the same as the current rate being used in option 2 mentioned here above with a two-third allocation to the preparatory codes and a one-third allocation to the obturation codes, which is a fair reflection of the ratio of time required to render these services. The proposed rate for code 8315 (RC irrigation/medication

visit) is similar to current code 8332 (RC prep visit – single canal). This approach results in a financial neutral cross-walk in the case of option 2 for the treatment of anterior and premolar teeth. It does however result in a reduction of fees for the treatment of molar teeth due to the reduced rate on the treatment of the first canal. We would thus recommended that the proposed rates of the new codes 8317 (RC prep molar - ea addnl) and 8321 (RC obturation molar ea addnl) be increased from R110.00 to R153.30 and from R55.10 to R76.70 respectively. This will ensure a financial neutral crosswalk (based on current option 2) on molar teeth for three a tooth with 3 canals and a small reduction in rates for teeth with four canals and approximately R30.00 less than what can currently be claimed in Option 1 with the maximum number of preparatory visits (limited to 4). The calculations are presented in table 2. This should depending on the current claim profile (which can only be determined on per tooth level), have no or a minimum financial implication (difference depends on the number of visits).

The current code 8334 (Re-prepare obturated canal) has been replaced by three codes: 8322 (RC retreat first canal); 8323 (RC retreat ant/prem ea addnl) and 8324 (RC retreat molar ea addnl) to improve accurate reporting and future RVU development. The rates proposed for all three codes is equal current code 8334 being used – the replacement and additions of the codes have no financial implications.

Code 8635 (Apex-/recalcification visit) is currently being used for all apexification/recalsification visits. Code 8634 has been added to be used for the initial visit and code 8635 revised to be used for the additional visits. This is necessary to enable future RVU development. The proposed rates for codes are similar and equal to that of code 8635 – the addition/revision of the codes have no financial implications.

There are currently two codes being used for periradicular surgery, codes 9015 (Apicectomy anterior) and 9016 (Apicectomy posterior). These codes are proposed to be deleted and replaced with five new codes to improve accurate reporting, recordkeeping and future RVU development. The proposed codes make provision for the first roots of anterior, premolar and posterior teeth respectively (codes 8636, 8637 and 8641) and then also for additional roots on anteriors/premolars and molars (codes 8639 and 8642). The proposed rates for the first roots are the same as the current rates for code 9015 and 9016 and the rates for the additional canals reduced with the same ratios as being done in the USA – the deletion and addition of the codes should not have any financial implications (Usually only one root per tooth; many providers bill per root/tooth). In some instances it may have reduced fees for the additional roots per tooth in effect. Impact can only be determined on a per tooth level.

Code 8331 (Repair perforation defects) was added to improve electronic recordkeeping and future RVU development. Code 8635 is currently being used to bill this service and the same rate is proposed – addition of code has not financial implication.

Code 8765 (Hemi-/resection/tunnel prep) was deleted - See periodontic services.

Periodontic Services

The nomenclature and descriptors used in the current periodontic services section were long due for revision to improve recordkeeping, reduce potential "loading" of invoices by code manipulation and also to enable RVU development. The following four codes are good examples of some of the inadequacies in the current schedule:

- Code 8749 - Flap operation with root planing and curettage and which may include not more than 3 of the following: bone contouring, chemical treatment of root surfaces, root resection, tooth hemisection, a mucogingival procedure, wedge resection, clinical crown lengthening, per quadrant (R 1034.10)
- Code 8751 - As item 8749, per sextant. (R 856.50)
- Code 8753 - Flap operation with root planing and curettage and will include more than 3 of the following: bone contouring, chemical treatment of root surfaces, root resection, tooth hemisection, a mucogingival procedure, wedge resection, clinical crown lengthening, per quadrant. (R 1281.70)
- Code 8755 - As item 8753, per sextant (R 1038.80)

The "cleaning-up" of the periodontic section of the schedule is a prerequisite for record keeping and RVU development. The proposed submission followed the same approach as the Americans and is supported. The above four codes have been deleted and four new codes (codes 8745/6/7/8) have been added for basic flap operations. Codes 8745/6 are used for flap operations without bone surgery and codes 8746/7 for flap operations with bone surgery. These codes are still used to obtain entry (as previously) to sub-mucosal tissues but the separate procedures have to be reported in addition to these codes:

Code 8745 (Flap w/o bone surg – 1-3 th/q) added.

Code 8746 (Flap w/o bone surg – 4+ th/q) added.

Code 8747 (Flap w/ bone surg – 1-3 th/q) added.

Code 8748 (Flap w/ bone surg – 4+ th/q) added.

The ideal situation would have been to determine RVUs for all the procedures. It is however almost impossible to determine the type and number of procedures that have been performed as part of previous codes 8749/51/53/55 (can only be done by contacting the individual providers and doing case evaluations). The utilisation by the periodontists during 2005 was however fairly low: 8749 x 206; 8751 x 508; 8753 x 395 and 8755 x 321. The calculations for these code submitted by SADA were done in an effort to determine a financial neutral cross-walk, which is not possible.

The rates for code 8745 and 8747 should, as a minimum be equal to that of current code 8756 (Crown lengthen hard tissue) - R 629.90. These procedures are also more or less equally rated in the USA. The rates for codes 8746 and 8749 should, as a minimum be equal to that of current code 8751 - R 856.50. We acknowledge that this is not a scientific approach but a much more realistic estimate for actual costs incurred.

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Codes 8774 (Guide tissue regen – resorb) and 8775 (Guide tissue regen – nonresorb) have been added. Most of the funders in the USA rates code 8774 and 8775 equal or almost equal to code 8756 (Crown lengthen hard tissue) - R 629.90. I am also of the opinion that this is a much more realistic estimate for actual costs incurred, but would leave the rates initially as proposed.

Codes 8776 (Subm autograft – 1-3 teeth) and 8777 (Subm autograft – 4+ teeth) have been added. It replaces old code 8772 (Connective tissue autograft – R519.80) and the suggested rates, similar to codes 8761 (Soft tissue autograft 1-3 th) and 8762 (Soft tissue autograft 4+ th) are supported - R415.40 and R772.70 respectively. This represents is a slight reduction (R4.40) on code 8772, but are then equal to the two current codes for more or less equal services.

Codes 8778 (Subm allograft – 1-3 teeth) 8779 (Subm allograft – 4+ teeth) has been added. Due to a lack in current schedule, these procedures, when performed, are reported by means of codes 8761 or 8762. The reduced rates as proposed by SADA are supported.

Code 8780 (Alveolar process preservation) has been added. The descriptor of this code indicates a service similar to current code 8766 (Bone regeneration w/o flap) and the suggested rate is supported.

Code 8765 (Hemi-/resection/tunnel prep) is currently being used to report three distinct services i.e., the (1) hemisection of a tooth, (2) resection of a root or (3) tunnel preparation. Code 8765 has been deleted and three new codes introduced to improved accurate reporting, electronic record keeping and UV development. The codes are 8784 (Hemisection of tooth), 8785 (Root resection) and 8786 (Tunnel preparation). The rate for current code 8765 includes access, which will now be submitted by reporting one of codes 8745/6/7/8. Code 8765 was reported 20 times during 2005 by periodontists. We are of the opinion that current GP rates should apply although is not scientifically calculated.

Code 8771 (Insert intra-pocket agent). The time proposed by SADA to perform the procedure is conservative.

Code 8740 (Periodontal maintenance) is an essential service to be rendered in the maintenance of the periodontium, following completion of a periodontal treatment plan. The rate should be similar to that of the code 8180 (specialist rate) as proposed is the submission. The service to be rendered is similar in nature and is therefore supported. This code will prevent the abuse of code 8179/8180 which should be deleted as mentioned here above.

Code 8769 (Remove membrane) deleted. Considered to be included in placement procedure – No financial implication. The code has been reported once by periodontists during 2005.

Code 8772 (Connective tissue autograft) deleted. Code has become redundant and is replaced by codes 8776 and 8777 – no financial implication.

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Code 8995 (Gingivectomy per jaw) is a duplicate and has been deleted. The code was historically listed in the maxillo-facial surgeons' schedule. One of codes 8743 (Gingivectomy/plasty 1-3 th/q) or 8741 (Gingivectomy/plasty 4+ th/q) have to be used. Code 8995 has been reported 40 times by maxillo-facial surgeons' during 2005.

Code 8725 (Prov splint extra&resin /sext) has been deleted and current code 8723 (Provisional splint – extracor) has to be reported with reduced rates as a result. Code 8725 has been reported 258 time and code 8723 only 101 times by GDP during 2005. The terminology has also been revised from “per sextant” to “per quadrant”, which may result in a further reduction in rates. The rate of code 8725 (R256.80) should be used as the bases for the calculations.

Codes 8768 (Unlisted periodontal procedure) and 8787 (Unlisted oral medicine procedure) have been deleted. Code 9099 (Unlisted dental procedure or service) has to be used for all unlisted dental procedures. The deletion has no financial implications.

Prosthodontic Services

Codes 8643 (Dentures compl w/ compl) and 8649 (Denture compl w/ compl) have been deleted. The two codes 8645 (Dentures compl w/ maj compl) and 8651 (Denture compl w/ maj compl) remained. The prosthodontists were unable to provide the workgroup with definitions for dentures “with complications” and dentures “with major complications”. The deletions of these two codes will result in the reporting of codes 8645 and 8651 with an increase of R639.30 and R213.40 respectively. Code 8643 has been reported 6 times and code 8643 has been reported 13 times during 2005 by prosthodontists. We could not find any international references for the purpose of benchmarking, and the current rates for these four codes are outside the norm if compared with benefit ratios paid in the USA. Code 8645 has been reported 110 times and code 8651 has been reported 137 times by prosthodontists during 2005. General dental practitioners also abuse these codes and we are of the opinion that the codes should be deleted from the NHRPL until proper descriptors for the use of these codes have been provided. Codes 8231 (Dentures complete) and 8232 (Denture complete) are currently used by both GDPs and specialists for “normal” dentures.

Code 8671 (Denture partl metal frame) has been deleted. This code was used by prosthodontists and included the resin bases. The traditional GDP code 8281 (Denture partial metal frame) has to be reported. The code has been reported 78 times by prosthodontists during 2005. The deletion of the code will have reduced rates for the prosthodontists as a result.

Maxillo-facial Prosthetic Services

Codes 8855 (Consult - cleft palate n/a off), 8856 (Consult - cleft palate subsqnt) and 8857 (Consult - cleft palate max) have been deleted. The standardise consultation and visits codes will be reported. Codes 8855/6/7 were reported 7 times, 8 times and 4 times respectively by all providers during 2005.

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Code 9134 (Unspec speech appliance) deleted. The code is currently being used for unspecified speech appliances and has no rate. Code 9099 (Unlisted dental procedure or service) has to be used for all unlisted dental procedures. The deletion has no financial implications.

Code 9174 (Unspecified burn appliance) deleted. The code is currently being used for unspecified burn appliances and has no rate. Code 9099 (Unlisted dental procedure or service) has to be used for all unlisted dental procedures. The deletion has no financial implications.

Code 8661 (Dentures diagnostic - cond inc) has traditionally been used by prosthodontists. Code 8658 (Denture interim complete) and 8659 (Denture interim partial) are the two codes listed in the traditional GDP schedule for this purpose. Code 8661 should be deleted to avoid a choice between codes for the same purpose. The deletion of code 8661 will, in the case of complete dentures result in a slight increase and in the case of complete dentures in a slight decrease for prosthodontist. Code 8661 has been reported 13 times during 2005.

Implant Services

Code 9193 (Addnl fee – implant in socket) added. The intention of this code is to compensate the provider for additional time when the implant is placed into a fresh extraction socket. No international equivalent could be found. Proper time studies have to be conducted before a rate can be determined.

Code 9194 (Surg plce transmuc endoss impl) added. The intention of this code is to differentiate between the surgical placement of normal endosseous implants and the so-called mini-implants. The latter do not require a surgical flap and the rates should be substantially lower than current codes 9183/4/5. Unfortunately no rate was submitted by SADA. It is estimated that it will take approximately 60% of the time required to place a normal implant and a specialist rate of R480.80 (60% of R801.40) is therefore recommended. This will result in substantial saving for both patients and funders.

Code 9195 (Addnl fee – single phase surg) added. The intention of this code is to compensate the provided for additional time when the one stage approach is used. No international equivalent could be found. Proper time studies have to be conducted before a rate can be determined.

Code 8539 (Crown implant resin w/mtl) added for accurate record keeping. Proposed rate is the same as other implant crowns and there will be no financial implications.

Codes 8541 (Crown implant temp – cemented) and 8542 (Crown implant temp – screw) added. The principle regarding temporary and provisional crowns has been discussed above. The rates proposed for the interim restorations are deducted from the rates of the definite procedures to ensure a financial neutral addition of these codes – no financial implications. The same apply to the two new codes 8543 (Crown implant prov – cemented) and 8544 (Crown implant prov – screw) that have been added.

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Code 8592 (Crown impl supported) deleted. Traditionally a prosthodontist code that has become redundant. The appropriate GDP code with the same specialist rates have to be used. The deletion of this code will have no financial implications.

Code 8549 (Crown retainer impl resn w/mtl) added for accurate record keeping. Proposed rate is the same as other implant crowns and there will be no financial implications.

Codes 8571 (Crown retainer impl temp – cem); 8572 (Crown retainer impl temp – scr); 8573 (Crown retainer impl prov – cem) and 8574 (Crown retainer impl prov – scr) were added. See code 8541 here above (temporary vs. definite restorations).

Code 8666 (Addnl fee – immediate loading) added. The intention of this code is to compensate the provided for additional time required during immediate loading of implants. No international equivalent could be found. Proper time studies have to be conducted before a rate can be determined.

Code 8668 (Metal base for implant denture) has been added to improve record keeping and to enable future RVU development. Code 8663 (Metal base to complete denture) is currently being reported for this service. The same rate as code 8663 is proposed and there will be no financial implications.

Code 8669 (Framework for implant denture) has been added to improve record keeping and to enable future RVU development. Code 8584 (Implant connector bar) is currently being reported for this service. The same rate as code 8584 is proposed and there will be no financial implications.

Code 8670 (Implant screw access closure) has been added for accurate reporting and future RVU development. The practitioners who charges for this service report code 8351 (Resin 1 surface anterior) and rate R138.80. It is difficult to estimate the impact of the codes since not all practitioners charge for the closure of the implant screw. The rate is in our opinion too high because the closure of the screw does not require the removal of tooth structure as the case of a one-surface resin restoration on a natural tooth. Code 8165 (Sedative filling) with a rate of R63.60, is also used for the ART technique, and is a more comparative service. No international equivalent could be found. The access is closed at a subsequent visit and the code is supported.

Code 8591 (Remove implant prosthesis) has been added for accurate reporting and future RVU development. Code 8135 (Remove in/onlay/crown) and rate is currently being used and there will be no financial implications.

Code 8596 (Repair implant crown/retainer) has been added for accurate reporting and future RVU development. Code 8413 (Repair crown) and rate (R141.10) is currently being used and there will be no financial implications. The rate submitted by SADA is much lower at R25.60.

Fixed Prosthodontic Services

Codes 8421 (Pontic – temporary); 8431 (In/onlay retainer temporary) and 8440 (Crown retainer temporary) have been added. See code 8360 (temporary vs. definite restorations) above. The rates proposed for these interim restorations are deducted from the rates of the definite restorations to ensure a financial neutral addition of these codes – no financial implications.

Code 8420 (Pontic – resin) added for accurate reporting. Proposed rate is similar to the lowest of the current pontics and no financial implication is foreseen.

Code 8618 (Retainer ceramic) added for accurate reporting and future RVU development. Code 8436 (In/onlay rtr ceram 2 surf) and rate is currently used for this purpose. No financial implications.

Code 8448 (Crown retainer resin) added for accurate reporting. Proposed rate is similar to the other crown retainers and there will be no financial implication.

Codes 8611 (Pontic sanitary), 8613 (Pontic posterior) and 8615 (Pontic anterior/premolar) have been deleted for accurate reporting and alignment with the GDP codes. The same crosswalk has previously been done with the GDPs and no financial implications are foreseen.

Oral and Maxillo-facial surgery

Code 8204 (A traumatic tooth/root removal) added. The intention of this code is to compensate the provider for additional time required conserving bone at the time of tooth removal. All extractions should be a-traumatic and the code is open for abuse. No international equivalent could be found. Proper time studies have to be conducted before a rate can be determined. The code will not be added to the NHRPL.

Codes 8938 (Surg removal of tooth 2nd+) and 8942 (Surg removal of impaction 2nd+) have been added to align the GDP and MFS schedules and to minimise the use of modifiers. GDPs did not previously charged lower rates for the 2nd surgical removal and may result in savings for the funders. Codes 8943 (Surg removal of impaction 2nd), 8945 (Surg removal of impaction 3rd+) and 8953 (Surg removal of roots 1st) have been deleted as part of the alignment process. The deletion of code 8945 will have an increase in rates as a result.

Codes 8918 (Brush biopsy) and 8920 (Collect cytological specimen) added have been added with a basic rate of R214.10. The proposed rate of the brush biopsy (R214.10) is the same as code 8917 (Biopsy of oral tissue soft), similar as in the USA. The proposed rate of code 8920 may be a bit high and should, if compared with the ratios used in the USA, not be more than 10% of code 8918.

Codes 8996 (Zygomaticus implant); 8998 (Transcut endoss implant) and 8999 have been added. Code 8999 (Craniofac transm endos implant) added. Proper time studies have to be conducted before a rate can be determined for these codes.

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Code 8957 (Alveoplasty w/wo extraction) has been deleted and replaced by codes 8955 (Alveoplasty w/ extr /quadr) and 8956 (Alveoplasty w/o extr /quadr) for accurate reporting and future RVU development. The rates for both codes are similar to current code 8957 and there will be no financial implications.

Code 8731 (Surgical Tx periodnt abscess) has been deleted because it is similar to code 9011 (duplicate code). The code has traditionally been in the periodontists' schedule and is replaced by current and similar code 9011 (Ins&dr abscess intra soft tiss). The deletion of the code will have a slight increase as result.

Codes 9036 (Maxilla open reduct LF1) and 9038 (Maxilla open rduct LF2mid1/3) have been added to eliminate the use of Modifier 8010 (+75%) on codes 9035 and 9037. The rates proposed have been calculated accordingly and there are no financial implications.

Codes 8850 (Tx of MPDS - 1st visit) and 8851 (Tx of MPDS - subseq visit) have been deleted. The standardised consultation and visits codes will be reported. Codes 8850/1 were reported 246 times and 165 times respectively by all providers during 2005. The rates are the same and there will be no financial implications (might be less because codes cannot be phased).

Code 8980 (Harvest bone coagulum) added. Code added for accurate reporting and future RVU development. Code 8979 (Harvest autogen graft intra) is currently being used to report this service. Proposed rate is the same as code 8979 and there will be no financial implications.

Codes 9001 (Alv ridge augment block 1-2th) and 9002 (Alv ridge augmt b/graft 3-5 th) added for accurate reporting and future RVU development. Proposed rates are similar to codes 9008 and 9009, which is currently used to report the service. There will be no financial implications.

Codes 9012 (Maxil sinus floor augm – limit); 9014 (Osteotomy sinus floor augment); 9067 (Distrac osteogenesis 1-2 teeth); 9068 (Distrac osteogenesis 3-5 teeth) and 9070 (Distrac osteogenesis full arch) have been added. No direct international equivalents could be found for the benchmarking of rates. Proper time studies have to be conducted before a rate can be determined.

Orthodontic Services

Codes 8870 (Control habits – removabl appl) and 8871 (Control habits – fixed appl) have been added. Code 8862 (Ortho Tx removable appl) and rate R 1069.80 is currently being used due to a lack in proper coding. The proposed rates are similar to that of codes 8233/4 (1 and 2 teeth partial) with a rate of R294.00. This will result in a huge reduction in rates.

Codes 8804 (Ortho appl placement visit), 8805 (Ortho periodic visit) and 8806 (Ortho retention visit) have been added to ensure accurate reporting and record keeping. These codes are part of the contract and are zero-rated – No financial implications.

Code 8807 (Ortho post treatment visit) added for accurate reporting and future RVU development. Code 8803 or 8801 is currently reported for this purpose. The proposed rate is equal to that of code 8803 and there will be no financial implications.

Supplementary Services

Codes 8903 (House/Hosp consultation), 8904 (House/Hosp consultation subseq), 8905 (After hours visit), 8907 (Subseq consult maximum /week), 9203 (House/Hosp consultation) and 9207 (After hours visit) have been deleted and replaced by the standardised codes for visits as being discussed here above.

Code 8148 (Use of operating microscope) has been added with the intention to compensate the provider for expenses incurred in the purchasing of a dental operating microscope. SADA submitted two examples (codes 227 and 228) from the hospital NHRPL schedule, which are both reported per case. The descriptor provided by SADA proposes reporting in units of 15 minutes due to the variety of procedures being performed under microscope (almost impossible to determine case lengths). This code will be zero rated until acceptable costing information has been provided.

Code "New" (Facility fee) has been added to compensate the provider for expenses incurred to render services in the surgery rather than in hospital. SAMA Modifier 0004 has been included as an example being used by medical practitioners (Fee of the procedure PLUS 100%). This approach does not reflect costs incurred (CMS principles) but is rather an incentive paid by funders for not utilising more expensive facilities. This code will not be added because the list of procedures it will be applicable to has not been identified. Such considerations are probably best left to specific arrangements between funders and providers.

Codes 8090 (Adm fee – medicine dispensed); 8091 (Adm fee – medicine used); 8092 (Adm fee – direct material) and 8093 (Adm fee – dental lab service) have been added and equivalent SAMA codes are presented for comparison purposes. These codes will not be added pending review of the medical practitioner fee schedule. Please note that if implemented, code 8092 will replace modifier 8025.

Codes 8480 (Cost of prefab metal crown); 8481 (Cost of prefab resin crown); 8482 (Cost of ortho attachment) and 8559 (Cost of resin block) have been added and are direct materials. Code 8559 enables accurate reporting (Code 8560 is currently used). This addition of these codes will have a minimal effect on costing.

Modifiers

Modifiers. The following modifiers have been deleted on request of CMS and BHF to minimise the use of modifiers:

- The modifiers that have been used to apply the 2/3 rule (Modifiers 8002 and 8004) have been deleted and rates calculated for each provider category.
- Modifier 8010 (Open reduction (+75%)) has been deleted. The modifier only applied to two codes 9035 and 9037. Codes 9036 (Maxilla open reduction LF1)

and 9038 (Maxilla open reduct LF2mid1/3) were added with no financial implications.

- Modifier 8023 (Fabr of inlay/onlay (+25%)) has become redundant with the introduction of codes 8385, 8569 and 8570.
- Modifier 8025 (Handling fee (+26%)) will be retained pending implementation of codes 8090 to 8093.

Modifier 8003 (Minimum fee for assistant surgeon). The minimum fee is currently expressed as a monetary value (R117.93). SAMA expresses the minimum fee as 36 clinical units and SADA proposes the minimum fee to be expressed as 10 UVs. The value of this modifier will be revised once acceptable costing has been received.

Modifier 8007 (Assistant surgeon – general dental practitioner). The rate is currently expressed as 15% of the reference price. SAMA expresses the rate as 20% of the fee for the specialist surgeon and SADA proposed a similar %. The current percentage will be retained pending revision of medical practitioner schedule.

Modifier 8008 (Emergency surgery – after hours). The rate is currently expressed as +25% of the appropriate reference price. SAMA expresses the rate as 12,00 clinical procedure units per half-hour or part thereof of the operating time for all members of the surgical team. SADA proposes the rate to be expressed as 10 UVs per half-hour or part thereof for all members of the surgical team. The value of this modifier will be revised once acceptable costing has been received.

Service Rules

Rule 009 - Surgery guidelines: Multiple procedures

There are inconsistencies between the approach followed by SADA and SAMA. Both approaches are listed in their submission. Harmonisation of medical and dental schedules should await the pending revision of the medical schedule.

Rule 010 - Orthodontic guidelines:

The South African Society of Orthodontic (SASO) has proposed a new set of rules to regulate the management of orthodontic services. There are two items that needs be highlighted:

1. Old Item 4 has been deleted: "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"

The deletion of this item has an increase between R1281.70 (Code 8861) and R4702.10 (Code 8866) for phased treatment as result – based on specialist rates. The theoretical argument is that the preliminary treatment should reduce the

severity (and thus the expenses) of future extensive treatment and that both stages should therefore be charged in full. It does however not always happen that second stage treatment is followed by a lower category (severity) of malocclusion. The SASO was requested by the working committee to submit rates if the rule has to be deleted but did unfortunately not comply with the request.

The recommended rule change will not be implemented.

2. Old item 6 has been deleted: The proposed deletion of this item does not have financial implication for most of the funders but may have financial implications for patients. Item 6 is a useful administrative guideline that regulated cost determination when patients are transferred. It provides a standardised method for the distribution of costs between two providers when a patient is transferred and protects the patient from being "overcharged". Since many funders do not provide full coverage for orthodontic services and the deletion of the item have no effect on them. The difference in fees is, in this instance, paid by the patient and/or funder who do provide full coverage. The technical team finds this guideline very useful and it is used by several funders in the USA for this purpose. It is recommended that the current guideline be retained.

One of the main challenges in orthodontic coding is to differentiate between the severity of malocclusions (e.g., mild, moderate, severe, and severe with complications). SASO was not able to provide proper descriptors to address this challenge and should be addressed in the NHRPL for 2008.

The administrative management codes added in the orthodontic section is a must for the electronic reporting and recordkeeping of orthodontic treatment and is supported. The codes report important visits in the treatment process and are the only source for accurate cost estimations. (Note: The utilisation of these codes is of vital importance for future UV development and has no financial implications).

South African Dental Association's Financial Model

There has historically been a set difference of 66.66% between the remuneration of general dental practitioners and specialists (the so-called 2/3 rule). This difference has changed over the years due to different annual percentage increases for general dental practitioners and specialists and negotiated higher increase for specific codes.

It is a general accepted principle that the remuneration of specialists are more than that of general dental practitioners. The difference in remuneration should however be based on the difference in labour while the application of the 2/3 rule also implies that the overhead costs of a GDP is 2/3 of that of a specialists. CMS has provided different labour rates for different categories of providers (based on government remuneration), which has been used by SADAs in their proposal to rectify this anomaly. GP rates have been used for the basis of the calculation when the procedure is mainly performed by GDPs and specialist rates when specialists mainly perform the procedure. The following need to be considered:

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- There is a slightly higher increase for GDP as a result for those codes where the current specialist rates are used for rate calculation – CPIX plus the adjusted difference in direct labour costs.
- Where the GDP rates are used the increase will be equivalent to the CPIX.
- The approach uses the overhead rate as determined by the Small Business Advisory Bureau as a common factor, which is subject to final approval by the technical committee. If the approach is not approved the current rates for GDPs and specialists will apply. The model provides for adjustment of the labour, overhead and CPIX rates.

This model cannot be implemented at this stage, due to the rejection of the costing submission. Current relativities between general and specialist practitioners will be retained where possible until an acceptable costing model has been provided.

Comments on Discovery Health's Response – NHRPL 2007 (DASA)

There is not many "structural adjustments" in SADA's NHRPL submission. The only real challenge within the NHRPL is imbedded in the revised clinical examinations. It should however be noted that SADAs own publication, i.e. "Dental Coding" is currently still divided into six distinct code lists for the different provider groups: (1) General Dental Practitioners; (2) Oral Pathologists; (3) Prosthodontists; (4) Periodontists; (5) Orthodontist; and (6) Maxillo-facial Surgeons, each with their appropriate sub-categories of services. These six code lists have been integrated into one, something that has already been done in the NHRPL since its first publication in 2004. The "considerable structural adjustment" therefore applies to SADA's own "Dental Coding" and not the NHRPL. The codes deleted are mainly duplications that exist between the different provider groups. This could not previously be done in the NHRPL because the different specialist groups could not achieve consensus on the nomenclature and descriptors among themselves.

SADA has, in their submission, based the rates on the current NHRPL 2006 schedule because they could not complete the required UV and RVU studies. This approach is in fact followed by the CMS in that the "as is" is considered the point of departure in developing the "to be", which will have to comply with the guidelines as provided by the CMS.

BHF was a member of the workgroup and has identified the representatives of the funding industry; Discovery Health should address their concerns regarding representation to their industry association, BHF. The goal of the CMS/BHF/SADA meetings (workgroup) was to assist SADA with the integration process of their six code lists into one and to ensure that the product complies with the guidelines as stipulated in Circular 69 of 2005. Much attention were given to the nomenclature and descriptors as to ensure accurate reporting and electronic record keeping as well as future UV and RVU development – a basic requirement for any cost allocation. BHF has from time to time provided feedback received from individual medical schemes.

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Both codes 8171 (Mouth guard) and code 8169 (Occlusal guard) are still in the schedule because they are distinct procedures and they have not been "encompassed" in another code e.g. "gum guards - bite plate code" as being indicated by Discovery Health.

The "unbundling" of temporary restorations (e.g., code 8400 – temporary crown) and definite restorations (e.g., 8411 - Crown porcelain w/ metal) was done, as explained here above, to enable accurate cost determination. The proposed rate for the temporary restoration has been deducted from the final restoration (e.g., Cost of code 8441 minus cost of code 8400). The total cost of the combined procedures is exactly the same as the current single procedure. Funders are currently paying for the temporary procedure whether it is provided by the practitioner or not. The "unbundling" will in fact result in a decrease in rates for the funders and not a 26% increase as being indicated by Discovery Health.