GOVERNMENT GAZETTE

OF THE

REPUBLIC OF NAMIBIA

N$10.95 WINDHOEK - 28 February 2001 No.2489

CONTENTS

Government Notice

MINISTRY OF HEALTH AND SOCIAL SERVICES

No. 31 2001

REGULATIONS MADE UNDER THE MEDICAL AND DENTAL PROFESSIONS ACT, 1993 (ACT 21 OF 1993)

The Minister of Health and Social Services, on the recommendation of the Medical Board, under section 50 of the Medical and Dental Professions Act, 1993 (Act 21 of 1993) has -

(a) made the regulations set out in the Schedule below; and

(b) revoked Government Notice No. R. 2268 of 3 December 1976.

SCHEDULE

Definitions

1. In these regulations, unless the context otherwise indicates, any word or expression defined in the Act shall have that meaning, and -

"Board" means the Medical Board, and in respect of the conducting of an inquiry by the Board itself, the members of the Board who are not members of the committee of preliminary inquiry;

"committee of preliminary inquiry" means a committee established by the Board in terms of the section 10(3) of the Act to investigate into a complaint;

"complaint" means a complaint, charge or allegation or improper conduct or misconduct against a registered person;

"disciplinary committee" means the disciplinary committee established under section 10(1)(a) of the Act, and includes the Board if itself holds an inquiry;

"inquiry" means a disciplinary inquiry held by the Board or a disciplinary committee in terms of Part V of the Act and these regulations;

"inspector" means a person appointed by the Board in terms of section 23(5) of the Act;

"member" means a member of the Board;

"president" means the president of the Board;

Lodging of complaint

2. A complaint must be in writing and be addressed to the secretary.

Procedure on receipt of complaint

3. (1) On receipt of a complaint the secretary may call for further information from the complainant to be furnished either by affidavit or otherwise as the secretary may require.

(2) The secretary shall in writing advise the registered person concerned of the complaint and the particulars thereof and request a written explanation from him or her before a date specified by the secretary, and warn the person that such explanation may be used in evidence against him or her.

(3) Notwithstanding subregulations (1) and (2) the secretary in consultation with the president, may refer the case direct to the chairperson of a committee of preliminary inquiry for consideration by the committee.

Procedure on receipt of further information or explanation

4. If further information or an explanation has been called for in terms of regulation 3(1) or (2), the secretary must on receipt of such information or explanation, submit the complaint and such information or explanation to the chairperson of the committee of preliminary enquiry, for consideration by that committee.

Further investigation or legal advice

5. The secretary, the committee of preliminary inquiry concerned or the chairperson of such committee may at any stage cause further investigation to be made and seek such legal advice or other assistance as may be necessary in relation to the complaint.

Decision of committee of preliminary inquiry

6. (1) If, upon consideration of a complaint, it appears to the committee of preliminary investigation -

(a) that the complaint, even if substantiated -

(i) does not constitute improper conduct or misconduct; or

(ii) for any other reason should not be the subject of an inquiry,

the committee may report to the Board that no disciplinary inquiry should be held and state its reasons therefor; or

(b) that an inquiry should be held into the conduct of the registered person, direct the secretary to arrange for the holding of a disciplinary inquiry.

Disciplinary inquiry

7. (1) The notice referred to in section 31(4) of the Act must be substantially in the form of Form 1 set out in the Annexure and must be accompanied by a charge formulated by the *pro forma* complainant with the said notice.

(2) If witnesses are to be summoned at the instance of the person charged, the secretary may require that person to deposit a sum of money succifient to cover the costs in connection therewith and the secretary may pay such costs from the amounts so deposited.

Procedure at disciplinary inquiry

8. (1) (a) The person charged or, if he or she is not present, his or her legal representative, shall be asked by the chairperson of the disciplinary committee to plead guilty or not guilty to the charge and the plea shall be so recorded.

(b) In the absence of the person charged a plea of guilty shall be entered only if that person has clearly and in writing under his or her own signature informed the secretary accordingly prior to the commencement of the inquiry.

(c) If the person charged or his or her legal representative refuses or fails to plead to the charge it must be so recorded and a plea of not guilty be entered, and a plea so entered has the same effect as if it had so been pleaded by that person.

(2) If a plea of guilty is entered the disciplinary committee must decide whether or not evidence is to be led and if a plea of not guilty is entered evidence must be led.

(3) (a) The *pro forma* complainant must be given the opportunity of stating the case against the person charged and of leading evidence in support thereof, whereafter the person charged has the right of stating his or her case and of leading evidence in support thereof.

(b) If the person charged is neither present or represented at the inquiry his or her written defence, statements made by him or her or on his or her behalf or explanations, if any, shall constitute his or her defence and must be submitted to the disciplinary committee.

(c) The case of the *pro forma* complainant and the person charged shall be closed after evidence has been led as contemplated in paragraph (a).

(4) The chairperson of the disciplinary committee may allow further evidence to be led or witnesses to be recalled by either the *pro forma* complainant or the person charged or by both after their cases have been closed.

(5) (a) After the evidence of a witness has been given, the other party has the right to cross-examine that witness, whereafter the chairperson, and members of the disciplinary committee, may put questions to the witness.

(b) Further cross-examination shall be allowed on any matter arising from questions put by the chairperson or any other member of the disciplinary committee.

(c) After cross-examination of a witness, the party by whom the witness is called has the right to re-examine that witness, but re-examination is confined to matters raised in cross-examination and questions posed in terms of paragraph (a).

(6) (a) Oral evidence must be taken on oath or affirmation by the chairperson of the disciplinary committee.

(b) The disciplinary committee may decline to admit evidence when a witness is not available for cross-examination or refuses to submit thereto.

(c) Written evidence given by way of affidavit or a solemn declaration by a witness who is not personally present is admissible with the consent of the opposing party.

(d) An appropriately authenticated copy of the record of proceedings before a court of law is on its mere production admissible as evidence at an inquiry and any non-rejected evidence reflected in such record constitutes *prima facie* evidence of issue concerned.

(e) The disciplinary committee may, if practicable and if it appears necessary, for the purposes of further examination or cross-examination, call a witness whose evidence appears in a record referred to in paragraph (d).

(7) After the parties have closed their cases the disciplinary committee may of its own accord call further witnesses or recall a witness to be questioned by the members of the committee and thereafter by the *pro forma* complainant and the person charged or his or her legal representative.

(8) (a) After all evidence has been given, the *pro forma* complainant has the right to address the disciplinary committee on the evidence and any legal questions involved.

(b) Thereafter the person charged or his or her legal representative likewise has the right to address the disciplinary committee on the evidence and any legal question involved.

(c) The *pro forma* complainant has the right to reply to points of law raised by the person charged or his or her legal representative in his or her address.

(9) (a) The disciplinary committee shall after the conclusion of a case deliberate thereon in *camera*.

(b) If the person charged is found not guilty the disciplinary committee must advise him or her accordingly and report its decision to the Board.

(c) The disciplinary committee may make a finding of not guilty to the charge even if a person charged has pleaded guilty.

(d) If the person charged is found guilty the disciplinary committee must decide whether the act or omission concerned constitutes improper conduct or misconduct, and must announce its finding to the parties accordingly forthwith and make its recommendation to the Board in this regard.

(10) (a) After a finding of guilty the *pro forma* complainant must furnish details to the disciplinary committee of any previous convictions, of the person charged under the Act or any law repealed by the Act.

(b) Proof of previous convictions referred to in paragraph (a) may be adduced by means of a certificate under the hand of the secretary indicating the nature of the conviction, the date thereof and the penalty imposed.

(c) If a person charged challenges the correctness of a certificate referred to in paragraph (b) a copy of the relevant record and a copy of the minutes of the Board or other competent body which the finding and the penalty were confirmed must be produced, after which the fact of conviction shall be regarded as proved.

(11) (a) The *pro forma* complainant and the person charged, or his or her legal representative, may make representation to the disciplinary committee and lead evidence, either orally or in writing, regarding a suitable penalty to be imposed, and may adduce evidence in support of the representations made.

(b) If the person charged is neither present nor represented, any written representations, statements made by him or her or on his or behalf or explanations, if any, which have a bearing on a penalty must be taken into account.

(c) A witness called in connection with a suitable penalty may be questioned by the other party and by the members of the disciplinary committee.

(12) (a) The disciplinary committee shall deliberate in *camera* upon the penalty to be imposed.

(b) A penalty being a caution, a reprimand or a caution and a reprimand, must immediately be imposed by the disciplinary committee, and reported to the Board.

(c) If the disciplinary committee decides to recommend a penalty other than that referred to in paragraph (b) -

(i) the penalty recommended must immediately be communicated to the parties concerned with reference to the rights of the accused in terms of subparagraph (iii);

(ii) the disciplinary committee must submit all relevant documents and the record of its inquiry together with its finding and recommendation to the Board;

(iii) the person charged is entitled to make, within 14 days after the finding of guilty by the disciplinary committee, concise written representations to the secretary for submission to the Board; and

(iv) if the Board decides to follow the recommendation of the disciplinary committee its decision must be communicated to the person charged forthwith.

13. Any decision of the disciplinary committee in regard to any issue arising in connection with or in the course of an inquiry must be communicated to the person charged during such inquiry.

14. The disciplinary committee may of its own accord or at the request of the *pro forma* complainant or of the person charged or his or her legal representative, adjourn an inquiry to such date, time and place as it may determine or as the secretary may by registered post communicate to the parties concerned.

Consideration by Board of recommendation of disciplinary committee

9. (1) The Board may vary, confirm or refuse to confirm the recommendation of the disciplinary committee or refer the case to the disciplinary committee for further consideration and report.

(2) The finding and the penalty (if any) confirmed by the Board on the person charged must be communicated to the parties in accordance with section 33(4) of the Act.

(3) The secretary must cause to be published in the Gazette any finding of guilty and the associated penalty with reference to the name of the person charged, the contravention and the penalty imposed on him or her.

Accessibility to disciplinary inquiry

10. (1) The proceedings at an inquiry is open to the public, but -

(a) any point arising in connection with or in the course of a disciplinary inquiry may be decided by the disciplinary committee in *camera*;

(b) any evidence adduced at an inquiry may on good cause shown in the discretion of the disciplinary committee be heard in *camera*;

(c) the disciplinary committee may on good cause shown in its discretion order that no person shall at any time in any way publish any information which would probably reveal the identity of any particular person, other than the person charged.

(2) A person who infringes or fails to comply with an order made under subregulation (1) is guilty of an offence and liable on conviction to a fine not exceeding N$2 000 or imprisonment for a period not exceeding six months or to both such fine and such imprisonment.

Subpoena

11. A summons to appear as a witness before the disciplinary committee or to produce any book, record, document or thing must be substantially in the form of Form 2 set out in the Annexure and contain the information required therein.

Inquiry conducted in terms of section 39 of the Act

12. The procedures prescribed in these regulations shall, with the necessary changes, apply to an inquiry conducted in terms of section 39 of the Act.

ANNEXURE

FORM 1

REPUBLIC OF NAMIBIA

MEDICAL AND DENTAL PROFESSIONS ACT, 1993:
FORM OF NOTICE TO ATTEND A DISCIPLINARY INQUIRY

(Section 31(4) of Act)

Dear Mr./Mrs./Miss .....

I have been directed to inform you that the complaint/charge/allegation* that you, being a

.....

.....

(state profession of registered person)

Duly registered as such under the Medical and Dental Professions Act, 1993 (Act 21 of 1993), are guilty of improper conduct or misconduct in that you

.....

.....

.....

has been brought before the Board, and will be considered at an inquiry of the Board/a disciplinary committee of the board* to be held .....

at .....

(place)

on .....

(date)

at ..... (time)

You are hereby requested to appear before the inquiry to establish any defence which you may wish to offer, but if you should decide not to do so, the Board/the disciplinary committee* may consider and deal with the charge in your absence in accordance with the regulations governing the conduct of disciplinary inquiries, a copy of which is enclosed.

If you wish your letter of ..... to constitute your defence, please notify me accordingly in writing within 14 days of the date of this letter.

If you wish to submit any further statement please do so in writing within 14 days of the date of this letter. Please note that any such further statement may be used in evidence at the inquiry.

You are also informed of your rights in terms of section 31(10) of the Medical and Dental Professions Act, 1993 (Act No. 21 of 1993), which reads as follows:

"Every person whose conduct is the subject of an inquiry under section 30 shall, if such person is present at such inquiry, have the right, by himself or herself or through a legal representative, to answer any complaint, charge or allegation against him or her and to be heard in his or her defence, and for such purpose -

(a) to give evidence under oath or affirmation;

(b) to call witnesses to testify on his or her behalf;

(c) to submit any document, book, record or any other thing relevant to the inquiry;

(d) to examine witnesses testifying against him or her.".

Signature of Secretary **Date**

* Delete whichever does not apply

FORM 2

REPUBLIC OF NAMIBIA

MEDICAL AND DENTAL PROFESSIONS ACT, 1993: NOMINATION FORM OF SUMMONS TO APPEAR BEFORE MEDICAL BOARD OR DISCIPLINARY COMMITTEE OF THE BOARD

To: .....
(full names and surname)

.....
(registered address)

You are hereby summoned to appear at .....
on the ..... day of ..... 20 ..... at ..... h .....
Before the Medical Board/a disciplinary committee of the Medical Board* established in terms of the Medical and Dental Professions Act, 1993 (Act No. 21 of 1993), to give evidence in respect of the following conduct .....
.....
of .....
registered under the said Act as .....
.....

and you are hereby directed to bring with you and then produce at the time and place as aforesaid the several books, records, documents and things specified in the list below, and then and there to testify all and singular things you know in relation to the said inquiry.

Give under the hand of the ..... Board this ..... day of ....., Two Thousand and .....

....

Signature of President/Secretary **Date**

* Delete whichever does not apply.

List of books, records, documents and things to be produced:

.....

.....

.....

.....

.....

.....

Note: Your attention is directed to section 31(8)(c) of the Medical and Dental Professions Act, 1993 (Act No. 21 of 1993), which reads as follows:

"(c) Any person who, having been duly summoned -

(i) refuses, or without sufficient cause faills to attend the inquiry in question at the time and place specified in the summons; or

(ii) refuses to take the prescribed oath or to make an affirmation when required by the person presiding at such inquiry to do so; or

(iii) leaves the inquiry in question without the consent of the person presiding at such inquiry, whether or not such person has given evidence; or

(iv) refuses to give evidence before the Board or refuses to answer fully and satisfactorily to the best of his or her knowledge and belief any question lawfully put to him or her or refuses to produce any book, record, document or thing which such person has in terms of the summons been required to produce, shall be guilty of an offence and on conviction be liable to a fine not exceeding N$2 000 or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment.".

General Notices

MINISTRY OF HEALTH AND SOCIAL SERVICES

No. 43 2001

TARIFFS OF FEES WHICH REGISTERED HOMOEOPATHS MAY CHARGE FOR PROFESSIONAL SERVICES RENDERED: ALLIED HEALTH SERVICES PROFESSIONS ACT, 1993

It is hereby made known that the Homoeopathic Board has, after consultation with the Council for Health and Social Services Professions and with the approval of the Minister of Health and Social Services, under section 39(1) of the Allied Health Services Professions Act, 1993 (Act No. 20 of 1993), determined the tariffs of fees set out in the Schedule, which may be charged for professional services rendered by a registered homoeopath under the said Allied Health Services Professions Act, 1993.

FREDA JESKE
SECRETARY OF THE
HOMOEOPATHIC BOARD Windhoek, 13 February 2001

GENERAL CODES GOVERNING THE FEES FOR THE YEAR 2001

Consultation:

-	08001 - Constitutional	N$2.50 per minute
-	08001 - Initial	N$80.00 - for 30 min
-	08002 - Subsequent	N$60.00 - for 30 min
-	08001/2 - Acute disease	N$60.00 - for 30 min
-	08001/2 - After hours	N$60.00 + 50% during the week + 100% during weekends and public holidays
-	08001/2 - Home visit	N$60.00 + 100% + N$1.00 per km from the consulting rooms.

Medicines:

-	08202 - Tables & Capsules (each)	N$0.61
-	08203- Liquid drops (per ml)	N$1.40
-	08204 - Pillules & granules (per ml)	N$1.40

Payment after every consultation, unless other arrangements are made with the practitioner.

MINISTRY OF HEALTH AND SOCIAL SERVICES

No. 44 2001

TARIFFS OF FEES WHICH REGISTERED PHYSIOTHERAPISTS MAY CHARGE FOR PROFESSIONAL SERVICES RENDERED: ALLIED HEALTH SERVICES PROFESSIONS ACT, 1993

It is hereby made known that -

(a) the Physiotherapy Board has, after consultation with the Council for Health and Social Services Professions and with the approval of the Minister of Health and Social Services, under section 39(1) of the Allied Health Services Professions Act, 1993 (Act No. 20 of 1993), determined the tariff of fees set out in the Schedule, which may be charged by a registered physiotherapist in respect of professional services rendered by him or her in the practice of his or her profession under the said Allied Health Services Professions Act, 1993; and

(b) Government Notice No. 57 of 16 March 1998 is hereby repealed.

M.B. BURMEISTER
SECRETARY OF THE
PHYSIOTHERAPY BOARD Windhoek, 9 February 2001

TARIFF OF FEES WHICH REGISTERED PHYSIOTERAPISTS MAY CHARGE IN RESPECT OF PROFESSIONAL SERVICES RENDERED

IT IS HEREBY MADE KNOWN THAT -

(a) The Physiotherapy Board has -

(i) after consultation with the Council for Health and Social Services Professions; and

(ii) with the approval of the Minister of Health and Social Services,

Under Section 39 of the Allied Health Services Professions Act, 1993 (Act 20 of 1993) determined the tariff of fees set out in the Schedule which may be charged by any registered physiotherapist in respect of professional services rendered by him or her in the practice of his or her profession under the said Allied Health Services Professions Act, 1993,; and

(b) the said fees shall come into operation on 1 January 2001.

M.B. BURMEISTER
SECRETARY: PHYSIOTHERAPY BOARD

SCHEDULE

DEFINITIONS

1. In this notice, unless the context otherwise indicates, any word or expression defined in the Allied Health Services Professions Act, 1993 (Act 20 of 1993), shall have that meaning, and

"Procedure" means the technique, equipment or apparatus used in the treatment of a condition;

"Unit" consists of -

(a) the cost of apparatus and the skill and knowledge used to perform any technique or apply the apparatus; and

(b) the responsibility and risk involved and the appropriate time spending on any procedure,

and the monetary value for one unit shall be N$0-69c.

GENERAL RULES GOVERNING THE FEES

001 Unless timely steps (i.e. 24 hours prior to the appointment) are taken to cancel an appointment the relevant fee may be charged, but shall not be payable by medical schemes. Each case shall however, be considered on merit and, if circumstances warrant, no fee shall be charged. Modifier 0001 to be quoted.

002 In exceptional cases where the fee is disproportionately low in relation to the actual services rendered by the practitioner, the practitioner shall provide motivation for a higher fee and such higher fee, as agreed upon between the practitioner and the scheme, may be charged.

003 Where a practitioner uses equipment which is not owned by that practitioner, a reduction of 15% of the relevant tariff will be applicable. Modifier 0003 must be quoted when this rule is applied.

004 In the case of prolonged or costly treatment, the practitioner should first ascertain from the scheme concerned whether it will accept financial responsibility in respect of such treatment, since the member may be subject to maximum annual benefits.

005 After a series of 20 treatments in respect of one patient for the same condition, the practitioner concerned shall report to the scheme as soon as possible if further treatment is necessary. Payment for treatments in excess of the stipulated number may be granted by the scheme after receipt of a letter from the practitioner concerned, motivating the need for such treatment.

006 "Emergency treatment" shall mean a bona-fide, justifiable emergency physiotherapy procedure performed at any hour, which requires the practitioner to travel to the patient or place of treatment.

The fee for all visits under this rule shall be the total fee plus 50% and must be motivated. Modifier 0006 must be quoted after the appropriate code number(s) to indicate that this rule is applicable.

008 The fee in respect of more than one procedure (save for evaluation and visiting items 407, 501, 502, 701, 702, 703, 704, 705, 801, 803, 901 and 903) performed at the same consultation or visit shall be the fee for the major procedure plus half the fee in respect of each additional procedure, but under no circumstances may fees be charged for more than three procedures carried out in the treatment of any one condition, modifier 0008 must then be quoted after the appropriate code numbers for the additional code numbers for the additional procedures to indicate that this rule is applicable.

009 When more than one condition requires treatment and each of these conditions necessitates an individual treatment, they shall be charged as individual treatments, full details of the nature of the treatments must be stated, modifier 0009 must then be quoted after the appropriate code number to indicate that this rule is applicable.

010 When the treatment times of two completely separate and different conditions overlap, the fee shall be the full fee for the one condition, and 50% of the fee for the other condition. Modifier 0010 must then be quoted after the appropriate code number to indicate that this rule is applicable.

012 Monetary values to be rounded off to the nearest 10 cents, on the basis that monetary values ending with a 1 to 4 cents value to be rounded off downwards, and 5 to 9 cents to be rounded off upwards. NB: Rounding off does not apply to amounts occurring once the modifies are used.

013 Where the physiotherapist preforms treatment away from the treatment rooms, travelling costs to be charged according to the aa-rate. Modifier 0013 must be quoted after the appropriate code numbers to show that this rule is applicable.

014 Physiotherapy services rendered in a nursing home or hospital. Modifier 0014 must be quoted after each code.

MODIFIERS

0001 Unkept appointment

0003 15% of the relevant tariff to be deducted where equipment used is not owned by the practitioner.

0006 Add 50% of the total fee for the treatment.

0008 Only 50% of the fee for these additional procedures may be charged.

0009 The full fee for the additional condition may be charged.

0010 Only 50% of the fee for the second condition may be charged.

0013 Travelling costs according to aa-Rate.

0014 Physiotherapy services rendered to a patient in a nursing home or hospital.

FEES FOR PROCEDURES

THE FEES FOR THE RESPECTIVE PROCEDURES MENTIONED IN THE SECOND COLUMN BELOW SHALL IN EACH CASE BE THE AMOUNT MENTIONED IN THE FOURTH COLUMN BELOW.

Code Number	Procedure	Unit	Monetary Value (N$)
RADIATION THERAPY/ MOIST HEAT / CRYOTHERAPY			
72001	Infra-Red, Radiant Heat Wax Therapy, hot packs	100	69.00
72005	Ultra Violet Light	150	104.00
72006	Laser Beam	150	104.00
72007	Cryotherapy	100	69.00
LOW FREQUENCY CURRENTS			
72103	Galvanism, Diodynamic Current, Tens	100	69.00
72105	Muscle and nerve stimulating currents	100	69.00
72107	Interferential therapy	150	104.00
HIGH FREQUENCY CURRENTS			
72201	Shortwwave diathermy	150	104.00
72203	Ultrasound	150	104.00
72205	Microwave	150	104.00

PHYSICAL MODALITIES

72301	Percussion, vibration	100	69.00
72302	Level 1: Massage	100	69.00
72303	Level 2: Myofascial release soft tissue mobilisation trigger point therapy	150	104.00
72304	Accupuncture	200	139.00
72305	Re-education of movement exercises (excluding ante- and post-natal exercises)	100	69.00
72307	Pre- and post- operative exercises and/or breathing exercises	100	69.00
72308	Group exercises (excluding ante- and post-natal exercises maximum of 10 in a group)	50	35.00
72309	Isokinetic treatment	200	139.00
72310	Neural tissue mobilisation	150	104.00
72313	Ante and post-natal exercises or counselling	100	69.00
72314	Lymph drainage	100	69.00
72315	Postural drainage	130	90.00
72317	Traction	150	104.00
72318	Upper respiratory nebulisation	100	69.00
72319	Nebulisation	150	104.00
72321	Intermittend positive pressure ventilation	130	90.00
72323	Suction: Level 1 (Including sputum specimen taken by suction)	100	69.00
72325	Suction: Level 2 (suction with involvement of lavage as a treatment in a special unit situation or in the respiratory compromised patient)	150	104.00
72327	Bagging (used on the intubated unconscious patient or in the severely respiratory distressed patient)	100	69.00
72328	Dry needling	200	139.00

MANIPULATION/MOBILISATION OF JOINTS OR IMMOBILISATION

72401	Spinal	200	139.00
72402	Pre meditated manipulation	200	139.00
72405	All other joints	150	104.00
72407	Immobilisation (excluding materials) Rule 008 does not apply.	100	69.00

REHABILITATION

72501	Rehabilitation where the pathology requires the undivided attention of the physiotherapist. Rule 008 does not apply.	200	139.00
72502	Hydrotherapy where the pathology requires the undivided attention of the physiotherapist. Rule 008 does not appy.	200	139.00
72503	Rehabilitation for central nervous system disorders (no other treatment modality may be charged in conjunction with this).	450	312.00
72504	EMG Biofeedback treatment	200	139.00
72505	Group rehabilitation (treatment of a patient with disabling pathology in an appropriate facility requiring specific equipment and supersivion, without individual attention for the whole treatment session, in accredited venue only and no charge may be levied by facility.	350	243.00
72507	Respiratory re-education and training.	200	139.00

EVALUATION

72701	Evaluation/councelling at the first visit only (to be fully documented)	100	69.00
72702	Complex evaluation/counselling at the first visit only (to be fully documented)	250	174.00
72703	One complete re-assessment during the course of the treatment, and/or counselling of the patient or his family.	100	69.00
72704	Lung function: Peak flow (once per treatment).	100	69.00
72705	Computerised/electronic test for lung pathology.	150	104.00
72801	Electrical test for diagnostic purposes (including it curve and isokinetic tests) for a specific medical condition.	350	243.00
72803	Effort test - multistage treatmill	350	243.00

VISITING CODES

72901	Treatment at a nursing home: Relevant fee plus (to be charged only once per day and not with every hospital visit.	100	69.00
72903	Domiciliary treatment: Relevant fee plus.	200	139.00

EQUIPMENT AND MATERIALS

72937	Bird or equivalent freestanding nebuliser excluding oxygen at hospital per day.	200	139.00
72938	Bird or equivalent freestanding nebuliser excluding oxygen domicilliary per day.	200	139.00
72939	Cost of appliances: Single items below N$1140.00 may be charged for at cost price plus 20%.		
72940	Cost of appliances: Single items below N$ 1140.00 may be charged for at cost price plus 20%.		

THE COST FOR THE EQUIPMENT AND MATERIALS SET OUT IN THE THIRD COLUMN BELOW OPPOSITE THE CODES AND PROCEDURES, RESPECTIVELY, AND USED IN ANY TREATMENT MAY, SUBJECT TO THE FOLLOWING CONDITIONS, BE CHARGED -

(a) Any equipment or material charged for, shall be part of the treatment.

(b) Equipment and material used shall become the proprty of the patient;

(c) Quantities charged for shall be measurable, and it is therefor advisable to use sizes easily measurable.

(d) Any equipment or material (like re-usable masks and nebulising tubes) sterilized and re-used for different patients may not be charged for.

CODE NUMBER	PROCEDURE	MATERIAL
72001	Infra red, wax therapy, red heat or hot pack	(a) Wax per ml used for patient (b) Plastic wrap per meter
72005	Ultra violet light	No material used
72006	Laser Beam	One alcohol Swab
72007	Cryotherapy	No material used
72103	Galvanism, diodynamic current, tens	(a) Saline per ml (b) amount of disposable electrodes (c) one alcohol swab (d) Ky gel per ml or sachet

72105	Galvanism, diodynamic current, tens	(a) Saline per ml (b) amount of disposable electrodes (c) one alcohol swab (d) Ky gel per ml or sachet
72107	Muscle and nerve stimulating currents.	(a) Saline per ml (b) amount of disposable electrodes (c) one alcohol swab
72201	Interferential therapy	Amount of disposable electrodes
72203	Shortwave diathermy	No material used
72205	Ultrasound	Ultrasound gel per ml or sachet
72301	Microwave therapy	No material used
72302	Percusions, vibrations	(a) Disposable mask for therapist (b) Disposable sputum cup
72303	Message; Myofascial release, soft tissue mobilisation, triggerpoint therapy	Lubrication medium (Talc, oil, cream or ointment per gm or ml used)
72304	Acupuncture	(a) Amount of disposable needles. (b) SWABS (c) Skin cleaning solution per ml

EXERCISE AND REHABILITATION

72305 72308 72501 72502 72505 72507		Any equipment or material given to patient to perform a home programme which then becomes the property of the patient, like autopully, cliniband per metre, theraputty per gm, pezziballs, crutches, walkers.
72315	Postural drainage	No material used
72317	Traction	DISPOSABLE HALTER
72319	Nebulisation	(a) Saline per ml (b) Disposable mask (c) Tubes per metre

NOTE: NO CHARGE MAY BE MADE FOR MEDICATION AS PHYSIOTHERAPISTS ARE CURRENTLY NOT ALLOWED TO DISPENSE OR STOCK MEDICATION.

72321	Intermittend positive pressure ventilation	(a) Saline per ml (b) Disposable mouth-piece (c) Tubes per metre
72323	Suction Level 1 (Sputum Specimen)	(a) Suction catherer (b) Sputum collection and e.g. luki-tube (c) Ky gel per ml or sachet (d) One pair sterile gloves (e) Sterile gauze swabs x quantity (f) Disposable mask
72325	Suction Level 2 (With Lavage)	(a) One pair sterile gloves (b) One suction catheter (c) Lubrication gel per ml or sachet (d) Sterile gauze swabs x quantity (e) Saline per ml (f) Syringe and needle (g) Disposable mask
72327	Bagging	No material used
72401	Spinal mobilisation	No materia used
72405	Periferal joint mobilisation	No material used
72407	Immobilisation	(a) Splints and Braces like ankle aircasts soft neck collars (b) Bandages and tape per roll (c) Elastoplast pre roll (d) Cottoonwool per roll

EVALUATIONS

72701 72702 72703 72704 72705 72801	(a) Disposable mouth-pieces for peakflow meter, lung function test. (b) Educational material (must be of good professional quality).

VISITING CODES

72901 72903	No material used

COMPOSITE FEES

72921 72923 72925 72927	As per individual codes

MINISTRY OF HEALTH AND SOCIAL SERVICES

No. 45 2001

TARIFF OF FEES WHICH REGISTERED DENTISTS MAY CHARGE FOR PROFESSIONAL SERVICES RENDERED: MEDICAL AND DENTAL PROFESSIONS ACT, 1993

It is hereby made known that the Dental Board has, after consultation with the Council for Health and Social Services Professions and with the approval of the Minister of Health and Social Services, under section 42(1) of the Medical and Dental Professions Act, 1993 (Act No. 21 of 1993), determined the tariff of fees set out in the Schedule, which may be charged for professional services rendered by a registered dentist under the said Medical and Dental Professions Act, 1993.

DR. C. de CHAVONNES-VRUGT
SECRETARY OF THE DENTAL BOARD Windhoek, 8 February 2001

INDEX

DENTAL BOARD OF NAMIBIA

NATIONAL SCHEDULE OF RECOMMENDED FEES AND GUIDELINES

GENERAL GUIDELINES

INTRODUCTION TO THIS PUBLICATION

1. This schedule includes procedures performed by general dental practitioners, maxillo-facial and oral surgeons, orthodontists, periodontists, prosthodontists and oral pathologists.
2. The DBN fees listed are considered to be reasonable, but are not binding on members and may be higher or lower, depending on individual circumstances. If a higher fee is charged, such actions may have to be justified by factors such as unusual complications, experience and ability of practitioner.
3. Dento-legal fees. Practitioners are entitled to remuneration if they are present at Court at the request of an advocate or attorney, even if they are not called to give evidence. The DBN recommends that for dento-legal work general practitioners base their fee on **N$ 669.00** per hour and specialists **N$ 999.00** per hour.

RULES

4. The following Rules apply to all practitioners

001 Item 8101 refers to a Full Mouth Examination, charting and treatment planning and no further examination fees/benefits shall be chargeable until the treatment plan resulting from this consultation is completed with the exception of Item 8102. This includes the issuing of a prescription where only medication is prescribed

Item 8104 refers to a consultation for a specific problem and not to a full mouth examination, charting and treatment planning. This includes the issuing of a prescription where only medication is prescribed

002 Except in those cases where the fee is determined "by arrangement", the fee for the rendering of a service which is not listed in this schedule shall be based on the fee in respect of a comparable service that is listed therein and Rule 002 must be indicated together with the tariff item

004 In exceptional cases where the tariff fee is disproportionately low in relation to the actual services rendered by a practitioner, such higher fee as may be mutually agreed upon between the dental practitioner and the patient/scheme may be charged and Rule 004 must be indicated together with the tariff item

008 (a) Every dentist shall render a monthly invoice for every procedure which has been completed irrespective of whether the total treatment plan has been concluded

(b) Every invoice shall contain the following particulars

(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) date on which every service was rendered
(vii) the nature and cost of every service and where applicable, the code number of the procedure or service
(viii) where the invoice is a photocopy of the original, certification by way of a rubber stamp or the signature of the dentist; and
(ix) a statement of whether the invoice is in accordance with the scale of benefits
(x) The name of the dentist rendering the service must be shown on the invoice

(M) 009 Dentists in general practice shall be entitled to charge two-thirds of the fees/benefits of specialists only for treatment that is not listed in the schedule for dentists in general practice and Modifier 8004 must be shown against any such item

Benefits in respect of specialists charging treatment procedures not listed in the schedule for that specialty, shall be allocated as follows

General Dental Practitioners Schedule	- 100%
Other Dental Specialists Schedules	- 2/3

010 Fees charged by dental technicians for their services (PLUS L) shall be shown on the dentist's invoice against the code 8099. Such dentist's invoice shall be accompanied by the actual invoice of the dental technician (or a copy thereof) and the invoice of the dental technician shall bear the signature of the dentist (or the person authorised by him) as proof that it has been compiled correctly. "L" comprises the fee charged by the dental technician for his services as well as the cost of gold and of teeth. For example, item 8231 is specified as follows

	N$
8231	X
8099 (8231)	Y
Total	N$(X+Y)

011 Modifiers may only be used where (M) appears against the item in the schedule/

8001 33 1/3% of the appropriate scheduled fee/benefit (see Note 4 - preamble to Maxillo-facial and oral surgery schedule)

8002 The appropriate scheduled fee/benefit + 50% (see Note 1 - preamble to Maxillo-facial and oral surgery schedule)

8003 The appropriate scheduled fee/benefit + 10% (see Note 5 - preamble to Perio schedule)

8004 Two-thirds of appropriate scheduled fee/benefit (see Rule 009)

8005 The appropriate scheduled fee/benefit up to a maximum of **N$ 508.00 (DBN fee)** (see Note 2 - preamble to Maxillo-facial and oral surgery schedule)

8006 50% of the appropriate scheduled fee/benefit (see Note 3 - preample to Maxillo-facial and oral surgery schedule)

8007 15% of the appropriate scheduled fee/benefit with a minimum of **N$ 305.00 (DBN fee)** (See preamble(s) under "oral surgery" in the schedule for GPs, the schedule for specialists in oral medicine and periodontics, and the schedule for specialists in Maxillo-facial and oral surgery

8008 The appropriate scheduled fee/benefit + 25% (see Note 5 - preamble to Maxillo-facial and oral surgery schedule, GPs' schedule)

8009 75% of the appropriate scheduled fee/benefit

8010 The appropriate schedule fee/benefit plus 75%

012 In cases where treatment is not listed in the schedule for dentists in general practice or specialists then the appropriate fee/benefit listed in the medical schedules shall be charged and the relevant item in the medical schedules must be indicated

013 Cost of material (VAT inclusive): This item provides for a charge for material where indicated against the relative item codes by the words (See Rule 013). Material to be charged for at cost plus a handling fee not exceeding 35%, up to **N$ 1,533.00**. A maximum handling fee of 10% shall apply above a cost of **N$ 1,533.00**. A maximum handling fee of **N$ 2,212.00** will apply. Note: Item 8220 (suture) is applicable to all registered persons

EXPLANATIONS

5. Additions, deletions and revisions

A summary listing of additions, deletions and revisions applicable to this Schedule is found in Appendix A
New code numbers added to the Schedule are identified with the symbol Σ placed before the code number
In instances where a code has been revised, the symbol * is placed before the code number

6. Tooth identification

Tooth identification is compulsory for all invoices rendered at the Recommended Scale of Benefits. It is recommended that practitioners charging fees as per the National Schedule of Recommended Fees follow the same format. Tooth identification is only applicable to procedures identified with the letter (T) in the mouth part (MP) column. 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

7. Treatment categories

Treatment categories (TC) of dental procedures are identified in the TC column of the schedule as follows

Basic dentistry	-	designated as (B) in this schedule
Intermediate dentistry	-	designated as (I) in this schedule
Advanced dentistry	-	designated as (A) in this schedule
Maxillo-facial and oral surgery	-	designated as (S) in this schedule

8. Abbreviations used in the Schedule

+D	Add fee/benefit for denture
+L	Add laboratory fee
A	Advanced dentistry (TC)
B	Basic dentistry (TC)
GP	General practitioner
I	Intermediate dentistry (TC)
S	Maxillo-facial and oral surgery (TC)
M	Modifier
MP	Mouth part
Na	not applicable
T	Tooth
TC	Treatment category

9. VAT

In Namibia VAT is levied on *all input costs* for a dental practice. Dental services in Namibia however are VAT exempt as defined by law. VAT is therefore not charged on dental services rendered.

I. GENERAL DENTAL PRACTITIONERS

PREAMBLE

(1) The dental procedure codes for general dental practitioners are divided into twelve (12) categories of services. The procedures have been grouped under the category with which the procedures are most frequently identified. The categories are solely for convenience in using the Schedule and should not be interpreted as excluding certain types of Oral Care Providers from performing or reporting such procedures. General practitioners are advised to become familiar with the details of these categories since it is similar to the *Current Dental Terminology Second Edition* (CDT-2) which was adopted in principle by the DBN.

(2)
(M) Procedures not described in the general practitioners' schedule should be reported by referring to the relevant specialist's schedule. Dentists in general practice shall be entitled to charge two-thirds of the fees/benefits of specialists only for treatment that is not listed in the schedule for dentists in general practice and Modifier 8004 must be shown against any such item (See Rules 009 and 011). There are no specific codes for orthodontic treatment in the current general practitioner's schedule, and the general practitioner must refer to the specialist orthodontist's schedule.

(3)
(M) Oral and maxillofacial surgery (Section J of the Schedule): The fee/benefit payable to a general practitioner assistant shall be calculated as 15% of the fee/benefit of the practitioner performing the operation, with the indicated minimum (see Modifier 8007). The patient must be informed beforehand that another dentist will be assisting at the operation and that a fee/benefit will be payable to the assistant. The assistant's name must appear on the invoice rendered to the patient.

I	GENERAL DENTAL PRACTITIONERS					
		N$				
Code	Procedure description	DBN	Notes		MP	TC
	A. DIAGNOSTIC					
	Clinical oral evaluations					
8101	Full mouth examination, charting and treatment planning (see Rule 001)	129.00				B
8102	Comprehensive consultation	297.00				B
	A comprehensive consultation shall include treatment planning at a separate appointment where a diagnosis is made with the help of study models, full-mouth x-rays and other relevant diagnostic aids. Following on such a consultation, the patient must be supplied with a comprehensive written treatment plan which must also be recorded on the patient's file and which must include the following: • Soft tissue examination • Hard tissue examination • Screening/probing of periodontal pockets • Mucogingival examination • Plaque index • Bleeding index • Occlusal Analysis • TMJ examination • Vitality screening of complete dentition					
8104	Examination or consultation for a specific problem not requiring full mouth examination, charting and treatment planning	86.00				B
	Radiographs/Diagnostic imagin					
8107	Intra-oral radiographs, per film	82.00				B
8108	Maximum for 8107	661.00				B
8113	Occlusal radiographs	129.00				B
8114	Hand-wrist radiograph	339.00				A
8115	Extra-oral radiograph, per film (i.e. panoramic, cephalometric, PA)	339.00				B
	Tests and laboratory examinations					
8117	Study models – unmounted or mounted on a hinge articulator	93.00		+L		B
8119	Study models – mounted on a movable condyle articulator	238.00		+L		B
8121	Photographs (for diagnostic, treatment or dento-legal purposes) per photograph	93.00				B
8811	Tracing and analysis of extra-oral film	39.00				B

	B. PREVENTIVE					
	Dental prophylaxis					
8155	Polishing only (including removal of plaque) – complete dentition	129.00				B
8159	Scaling and polishing	238.00				B
	Where item 8159 is applied, Item 8155 can not be charged					
	Topical fluoride treatment (office procedure)					
8161	Topical application of fluoride (prophylaxis excluded) - complete dentition	129.00				B
	(Excluding scaling and/or polishing)					
	Other preventive services					
8151	Oral hygiene instructions	129.00				B
	The patient must be informed prior to the service being rendered that a fee will be levied for oral hygiene instruction					
*8153	Follow-up visit for re-evaluation of oral hygiene (if no other preventive treatment is performed during the same visit)	93.00				B
8163	Fissure sealant - per tooth	82.00			T	B
	Chargeable to a maximum of two teeth per quadrant					
	Space maintenance (passive appliances)					
	Passive appliances are designed to prevent tooth movement					
8173	Space maintainer – fixed, per abutment unit	238.00		+L		B
8175	Space maintainer – removable (all-inclusive fee)	307.00		+L		B
	C. RESTORATIVE					
	Amalgam restorations (including polishing)					
	All adhesives, liners and bases are included as part of the restoration. If pins are used, they should be reported separately.					
	See Codes 8345, 8347 and 8348 for post and/or pin retention DBN fees exclude amalgam bonding agents (code 8146).					
8341	Amalgam - one surface	140.00			T	B
8342	Amalgam - two surfaces	193.00			T	B
8343	Amalgam - three surfaces	256.00			T	B
8344	Amalgam - four or more surfaces	315.00			T	B
	Resin restorations					
	Resin refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Light-curing, acid etching and adhesives (including resin bonding agents) are included as part of the restoration. Glass ionomers, when used as restorations should be reported with these codes. If pins are used, they should be reported separately.					
	See Codes 8345, 8347 and 8348 for post and/or pin retention NAMAF benefits are inclusive of direct pulp capping (code 8301) and rubber dam application (code 8304)					
8351	Resin – one surface, anterior	156.00			T	B
8352	Resin – two surfaces, anterior	213.00			T	B
8353	Resin – three surfaces, anterior	224.00			T	B
8354	Resin – four or more surfaces	332.00			T	B
8367	Resin – one surface, posterior	197.00			T	B
8368	Resin – two surfaces, posterior	268.00			T	B

8369	Resin – three surfaces, posterior	344.00			T	B
8370	Resin – four or more surfaces, posterior	416.00			T	B
	NOTES TO AMALGAM AND RESIN RESTORATIONS On anterior teeth, it is considered correct to charge for resin restorations, per restoration placed eg. a Class V and a Class IV restoration on a central incisor would attract fees for 8351 and 8354. On posterior teeth, it is considered correct to charge per surface treated if a similar material was used and not per restoration e.g., a Class I occlusal amalgam and a Class V buccal amalgam on tooth 28 would attract a fee for code 8342. In rare cases, it may occur that an occlusal amalgam on tooth 16 and a buccal resin on the same tooth in a patient with an unusually wide smile, may be necessary and fees could then be raised against code 8341 and 8367. For purposes of benefit allocation, items 8351 to 8354 are applicable per restoration (more than once per tooth), whereas items 8341 to 8344 or 8367 to 8370 are applicable once only per tooth					
	Gold foil restorations					
	See the specialist prosthodontist schedule					
	Inlay/Onlay restorations					
	METAL INLAYS					
8358	Inlay, metallic – one surface, anterior	407.00		+L	T	A
8359	Inlay, metallic – two surfaces, anterior	595.00		+L	T	A
8360	Inlay, metallic – three surfaces, anterior	995.00		+L	T	A
8365	Inlay, metallic – four or more surfaces, anterior	1 198.00		+L	T	A
8361	Inlay, metallic – one surface, posterior	407.00		+L	T	A
8362	Inlay, metallic – two surfaces, posterior	596.00		+L	T	A
8363	Inlay, metallic – three surfaces, posterior	995.00		+L	T	A
8364	Inlay, metallic – four or more surfaces, posterior	1 198.00		+L	T	A
	CERAMIC AND/OR RESIN INLAYS					
	Porcelain/ceramic inlays presently include either all ceramic or porcelain inlays. Composite/resin inlays must be laboratory processed					
	NOTE: Both DBN fees exclude the application of a rubber dam (code 8304)					
8371	Inlay, ceramic/resin – one surface	486.00		+L	T	A
8372	Inlay, ceramic/resin – two surfaces	720.00		+L	T	A
8373	Inlay, ceramic/resin - three surfaces	1 190.00		+L	T	A
8374	Inlay, ceramic/resin - four or more surfaces	1 442.00		+L	T	A
8560	Cost of ceramic block				T	A
	Applicable to computer generated prosthesis only					
(M)	NOTES 1. In some of the above cases (e.g. Direct hybrid inlays) +L may not necessarily apply 2. In cases where the direct hybrid inlays are used and +L does not apply, Modifier 8008 may be used 3. See the General Practitioner's Guideline to the correct use of treatment codes for computer generated inlays.					

	Crowns – single restorations					
	The fees/benefits include the cost of temporary and/or intermediate crowns. See code 8193 (osseo integrated abutment restoration) in the 'fixed prosthodontic' category for crowns on osseo-integrated implants/					
8401	Cast full crown	1 528.00		+L	T	A
8403	Cast three-quarter crown	1 528.00		+L	T	A
8405	Acrylic jacket crown	1 528.00		+L	T	A
8407	Acrylic veneered crown	1 528.00		+L	T	A
8409	Porcelain jacket crown	1 528.00		+L	T	A
8411	Porcelain veneered crown	1 528.00		+L	T	A
	Other restorative services					
8133	Re-cementing of inlays, crowns or bridges - per abutment	129.00		+L	T	B
	In some cases where item 8133 is used +L may not apply					
8135	Removal of inlays and crowns (per unit) and bridges (per abutment) or sectioning of a bridge, part of which is to be retained as a crown following the failure of a bridge	256.00		+L	T	A
8137	Temporary crown placed as an emergency procedure	442.00		+L	T	A
	Not applicable to temporary crowns placed during routine crown and bridge preparations i.e. where the impression for the final crown is taken at the same visit					
8146	Resin bonding for restorations	107.00				
	Applicable to any metal restorations, crowns or conventional bridges, per abutment except Maryland type bridges					
8157	Re-burnishing and polishing of restorations - complete dentition	129.00				B
	(Not applicable to restorations recently done)					
8330	Removal of fractured post or instrument and/or bypassing fractured endodontic instrument	168.00			T	B
	NOTE: DBN fees exclude the application of a rubber dam (code 8304)					
8345	Preformed post retention, per post	191.00			T	B
	(See code 8379)					
8347	Pin retention for restoration, first pin	129.00			T	B
8348	Pin retention for restoration, each additional pin	110.00			T	B
	A maximum of two additional pins may be charged					
8349	Carving or contouring a plastic restoration to accommodate an existing removable prosthesis	63.00			T	B
8355	Composite veneers (Direct)	407.00			T	B
8357	Preformed metal crown	273.00			T	B
8366	Pin retention as part of cast restoration, irrespective of number of pins	197.00			T	A
8376	Prefabricated post and core in addition to crown The core is built around a prefabricated post(s)	528.00			T	B
8379	Cost of posts	Rule 013			T	A
	Applicable to pre-fabricated noble metal, ceramic, iridium and pure titinium posts – see code 8345					
8391	Cast post and core – single	309.00		+L	T	A
8393	Cast post and core – double	486.00		+L	T	A
8395	Cast post and core – triple	711.00		+L	T	A
8396	Cast coping	199.00		+L	T	A

8397	Cast core with pins	486.00		+L	T	A
	This service is usually provided on grossly brokendown vital teeth, and may not be charged when a post has been inserted in the tooth in question					
8398	Core build-up, including any pins	486.00			T	B
	Refers to building up of anatomical crown when restorative crown will be placed, irrespective of the number of pins used					
8413	Facing replacement	298.00		+L	T	A
8414	Additional fee for provision of crown within an existing clasp or rest	93.00		+L	T	A
	D. ENDODONTICS Preamble 1. The Namibian Dental Board has ruled that, with the exception of diagnostic intra-oral radiographs, fees/benefits for only three further intra-oral radiographs may be charged for each completed root canal therapy on a single-canal tooth; or a further five intra-oral radiographs for each completed root canal therapy on a multi-canal tooth. 2. The DBN benefit for the application of a rubber dam (See code 8304 in the category "Adjunctive General Services") may only be charged concurrent with the following procedures, otherwise no benefits. 3. Gross pulpal debridement, primary and permanent teeth for the relief of pain (code 8132) 4. The Namibian Dental Board has ruled that, with the exception of diagnostic intra-oral radiographs, fees/benefits for only three further intra-oral radiographs may be charged for each completed root canal therapy on a single-canal tooth; or a further five intra-oral radiographs for each completed root canal therapy on a multi-canal tooth.					
	5. The Namibian Dental Board has ruled that, with the exception of diagnostic intra-oral radiographs, fees/benefits for only three further intra-oral radiographs may be charged for each completed root canal therapy on a single-canal tooth; or a further five intra-oral radiographs for each completed root canal therapy on a multi-canal tooth. 6. The DBN benefit for the application of a rubber dam (See code 8304 in the category "Adjunctive General Services") may only be charged concurrent with the following procedures, otherwise no benefits. 7. Gross pulpal debridement, primary and permanent teeth for the relief of pain (code 8132) 8. Apexification of a root canal (code 8305) 9. Pulpotomy (code 8307) • Complete root canal therapy (codes 8328, 8329 and 8332 to 8340 • Removal or bypass of a fractured post or instrument (code 8330) • Bleaching of non vital teeth (codes 8325 and 8327) and • Ceramic and or resin inlays (codes 8371 to 8374) 10. After endodontic preparatory visits (codes 8332, 8333 and 8334) have been charged, endodontic treatment completed at a single visit (codes 8329, 8338, 8339 and 8340) may not be levied.					
8301	Direct pulp capping	60.00			T	B
8303	Indirect pulp capping	169.00			T	B
	The permanent filling is not completed at the same visit					

• = New Code * = Revised Code

	Pulpotomy					
8307	Amputation of pulp (pulpotomy)	169.00			T	B
	No other endodontic procedure may, in respect of the same tooth, be charged concurrent to code 8307 and a completed root canal therapy should not be envisaged (code 8304 excluded)					
	Endodontic therapy (including treatment plan, clinical procedures and follow-up care)					
	PREPARATORY VISITS (OBTURATION NOT DONE AT SAME VISIT)					
8332	Single-canal tooth, per visit	129.00			T	B
	A maximum of four visits per tooth may be charged					
8333	Multi-canal tooth, per visit	178.00			T	B
	A maximum of four visits per tooth may be charged					
	OBTURATION OF ROOT CANALS AT A SUBSEQUENT VISIT					
8335	First canal - anteriors and premolars	584.00			T	B
8328	Each additional canal - anteriors and premolars	238.00			T	B
8336	First canal - molars	803.00			T	B
8337	Each additional canal - molars	238.00			T	B
	PREPARATION AND OBTURATION OF ROOT CANALS COMPLETED AT A SINGLE VISIT					
8338	First canal - anteriors and premolars	890.00			T	B
8329	Each additional canal - anteriors and premolars	298.00			T	B
8339	First canal - molars	1 224.00			T	B
8340	Each additional canal - molars	298.00			T	B
	Endodontic retreatment					
8334	Re-preparation of previously obturated canal, per canal	191.00			T	B
	Apexification/recalcification procedures					
8305	Apexification of root canal, per visit	169.00			T	B
	No other endodontic procedures may, in respect of the same tooth, be charged concurrent to code 8305 at the same visit (code 8304 excluded)					
	Apicoectomy/Periradicular services					
8229	Apicoectomy including retrograde filling where necessary – incisors and canines	638.00			T	S
	Other endodontic procedures					
*8132	Gross pulpal debridement, primary and permanent teeth Gross pulpal debridement for the relief of acute pain prior to conventional root canal therapy (not to be used by provider completing endodontic treatment in a single visit) (See note 2 in the preamble above)	186.00			T	B
8136	Access through a prosthetic crown or inlay to facilitate root canal treatment	99.00			T	B
8308	Bleaching of vital teeth, per arch, per visit (See code 8309 for home bleaching)	1 095.00				A
8309	Supply of and instruction for home bleaching (self-applied bleaching) applicator	178.00		+L		
	See code 8310 in the section 'Adjunctive general services' for materials supplied					
8311	Follow-up visit for home bleaching, per visit, where no other treatment is performed at the same visit	86.00				

• = New Code * = Revised Code

	A maximum of three additional visits may be charged					
8325	Bleaching of non-vital teeth, per tooth as a separate procedure	328.00			T	A
8327	Each additional visit for bleaching of non-vital tooth as a separate procedure	152.00			T	A
	A maximum of two additional visits may be charged					
	E. PERIODONTICS					
	Surgical services (including usual postoperative care)					
8185	Gingivectomy-gingivoplasty, per quadrant	703.00				A
8186	Gingivectomy-gingivoplasty, per sextant	558.00				A
	Adjunctive periodontal services					
	1. A periodontal screening (code 8176) is a procedure carried out as part of a continuing maintenance programme in a periodontally compromised patient. The screening should include a complete charting, bleeding index and plaque index, measuring of all pocket depths and recording of all such measurements					
	2. Note to codes 8177, 8178, 8179, 8180, 8182 and 8184/ Nota tot kodes 8177, 8178, 8179, 8180, 8182 en 8184: A periodontally compromised patient shall be defined as a patient presenting with a diagnosis of either chronic adult periodontitis, juvenile periodontitis or rapidly progressive periodontitis, confirmed by a CPITN index of 3 or 4; and which diagnosis has been arrived at by the carrying out of a periodontal screening (8176) and CPITN index or a comprehensive consultation (8102) with substantiated clinical records					
	3. This diagnosis must be reviewed within a period of three years using the same criteria as in 1 above					
8182	Root planing with or without periodontal curettage, per quadrant	535.00				A
8184	Root planing with or without periodontal curettage, per sextant	427.00				A
	Codes 8182 and 8184 may not to be charged concurrent with a prophylaxis (code and 8159) and only if a comprehensive consultation (8102) or a periodontal screening (8176) has been performed at a prior visit					
	Other periodontal services					
8176	Periodontal screening	156.00				B
8177	Oral hygiene instruction for the periodontally compromised patient	197.00				B
	The patient must be informed prior to the service being rendered that a fee will be levied for oral hygiene instruction.					
8178	Oral hygiene evaluation for the periodontally compromised patient	107.00				B
8179	Plaque removal for the periodontally compromised patient	148.00				B
*8180	Scaling and polishing for the periodontally compromised patient	240.00				B
	F. PROSTHODONTICS (REMOVABLE					
	Complete dentures (including routine post-delivery care)					
8231	Full upper and lower dentures inclusive of soft bases or metal bases, where applicable	2 083.00		+L		B
	(DBN fee excludes Codes 8243 and 8279)					

8232	Full upper or lower dentures inclusive of soft base or metal base, where applicable	1 074.00		+L		B
	(DBN fee excludes Codes 8243 and 8279)					
	Partial dentures (including routine post-delivery care)					
8233	Partial denture, one tooth	596.00		+L		B
8234	Partial denture, two teeth	596.00		+L		B
8235	Partial denture, three teeth	891.00		+L		B
8236	Partial denture, four teeth	891.00		+L		B
8237	Partial denture, five teeth	891.00		+L		B
8238	Partial denture, six teeth	1 185.00		+L		B
8239	Partial denture, seven teeth	1 185.00		+L		B
8240	Partial denture, eight teeth	1 185.00		+L		B
8241	Partial denture, nine or more teeth	1 185.00		+L		B
8281	Metal (e.g. chrome cobalt, gold, etc.) base to partial denture, per denture	1 586.00		+L		B
	The procedure refers to the metal framework only, and includes all clasps, rests and bars (i.e., 8251, 8253, 8255 and 8257). See codes 8233 to 8241 for the resin denture base required concurrent to 8281					
	Adjustments to dentures					
8275	Adjustment of denture	93.00				B
	(After six months or for patient of another practitioner)					
	Repairs to complete or partial dentures					
8269	Repair of denture or other intra-oral appliance	166.00		+L		B
	A dentist may not charge professional fees for the repair of dentures if the patient was not personally examined; laboratory fees, however, may be recovered.					
8270	Add clasp to existing partial denture (One or more clasps)	110.00		+L		B
	Code 8270 is in addition to code 8269					
8271	Add tooth to existing partial denture (One or more teeth)	110.00		+L		B
	Code 8271 is in addition to code 8269					
8273	Additional fee/benefit where one or more impressions are required for 8269, 8270 and 8271	93.00		+L		B
	Denture rebase procedures					
8261	Re-model of denture	807.00		+L		B
	Denture reline procedures					
8259	Reline of denture (laboratory	486.00		+L		B
8263	Reline of denture in selfcuring acrylic (intra-oral)	308.00				B
8267	Soft base re-line per denture (heat cured)	711.00		+L		B
	Code 8267 may not be charged concurrent with codes 8231 to 8241					
	Other removable prosthetic services					
8243	Soft base to new denture	181.00		+L		
8251	Cast gold clasp or rest per clasp or rest	110.00		+L		A
8253	Wrought gold clasp or rest per clasp or rest	110.00		+L		A
8255	Stainless steel clasp or rest per clasp or rest	110.00		+L		B
8257	Lingual bar or palatal bar	152.00		+L		B

	Codes 8251, 8253, 8255 and 8257 may not be charged concurrent to codes 8169 (biteplate), 8175 (space maintainer), 8269 (repair of denture) or 8281 (metal framework)					
8265	Tissue conditioner and soft self-cure interim re-line, per denture	204.00				B
8277	Gold inlay in denture	204.00		+L		
	(NAMAF benefit by arrangement)					
8279	Metal (e.g. chrome cobalt, gold, etc.) base to full denture	638.00		+L		-
	G. MAXILLOFACIAL PROSTHETICS					
	See the schedule for specialist prosthodontists					
	H. IMPLANT SERVICES					
	Report surgical implant procedures using codes in this section; prosthetic devices should be reported using existing fixed or removable prosthetic codes/					
	Endosteal implants					
	Endosteal dental implants are placed into the alveolar and/or basal bone of the mandible or maxilla and transect only one cortical plate					
8194	Placement of a single osseo-integrated implant per jaw	1 274.00			T	S
8195	Placement of a second osseo-integrated implant in the same jaw	956.00			T	S
8196	Placement of a third and subsequent osseo-integrated implant in the same jaw per implant	638.00			T	
8197	Cost of implants	Rule 013				
8198	Exposure of a single osseo-integrated implant and placement of a transmucosal element	472.00			T	S
8199	Exposure of a second osseo-integrated implant and placement of a transmucosal element in the same jaw	357.00			T	S
8200	Exposure of a third and subsequent osseo-integrated implant in the same jaw, per implant	236.00			T	S
	Eposteal implants					
	Eposteal (subperiosteal) dental implants receive their primary bone support by means of resting on the alveolar bone					
	See the specialist maxillo-facial and oral surgeons schedule					
	Transosteal implants					
	Transosteal dental implants penetrate both cortical plates and pass through the full thickness of the alveolar bone					
	See the specialist maxillo-facial and oral surgeons schedule					
	I. PROSTHODONTICS, FIXED					
	The words 'bridge' and 'bridgework' have been replaced by the statement 'fixed partial denture' Each abutment and each pontic constitutes a unit in a fixed partial denture					
	Fixed partial denture pontics					
8420	Sanitary pontic	745.00		+L	T	A
8422	Posterior pontic	995.00		+L	T	A
8424	Anterior pontic (including premolars)	1 247.00		+L	T	A
	Fixed partial denture retainers – inlays/onlays					
	See inlay/onlay restorations for inlay/onlay retainers					
8356	Bridge per abutment - only applicable to Maryland type bridges	596.00		+L	T	A

	Only applicable to Maryland type bridges. Report per abutment. Report pontics seperately (see codes 8420, 8422 and 8424)					
	Fixed partial denture retainers – crowns					
	See crowns, single restorations for crown retainers					
8193	Osseo-integrated abutment restoration, per abutment	1 980.00		+L	T	A
	See the 'General Practioner's Guidelines to the correct use of treatment codes' for the application(s) of this code					
	J. ORAL AND MAXILLOFACIAL SURGERY					
	See the specialist maxillo-facial and oral surgeons schedule for surgical services not listed in this schedule					
	Extractions					
8201	Single tooth	129.00			T	B
	Code 8201 is charged for the first extraction in a quadrant					
8202	Each additional tooth in the same quadrant	72.00			T	B
	Code 8202 is charged for each additional extraction in the same quadrant.					
	Surgical extractions (includes routine postoperative care)					
	Code 8220 is applicable when sutures are provided by practitioner (Rule 013)					
*8209	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap, removal of bone and/or section of tooth Includes cutting of gingiva and bone, removal of tooth structure and closure	345.00			T	S
8210	Removal of unerupted or impacted tooth – first tooth	922.00			T	S
8211	Removal of unerupted or impacted tooth – second tooth	496.00			T	S
8212	Removal of unerupted or impacted tooth – each additional tooth	281.00			T	S
*8213	Surgical removal of residual tooth roots (cutting procedure) Includes cutting of gingiva and bone, removal of tooth structure and closure	500.00			T	S
*8214	Surgical removal of residual tooth roots (cutting procedure), each subsequent tooth Includes cutting of gingiva and bone, removal of tooth structure and closure	380.00			T	S
	Other surgical procedures					
8188	Biopsy – intra-oral	330.00				S
	This item does not include the cost of the essential pathological evaluations					
8215	Surgical exposure of impacted or unerupted teeth for orthodontic reasons	1 067.00			T	S
	Reduction of dislocation and management of other temporomandibular joint dysfunction					
8169	Bite plate for the treatment of TMJ dysfunction, or occlusal guards.	496.00		+L		B
	Repair of traumatic wounds					
8192	Appositioning (i.e., suturing) of soft tissue injuries	638.00				S
	K. ORTHODONTICS					

• = New Code * = Revised Code

	See the specialist orthodontist schedule for orthodontic services					
	L. ADJUNCTIVE GENERAL SERVICES					
	Unclassified treatment					
8131	Emergency treatment where no other treatment item is applicable or applied for treatment of the same tooth	129.00			T	B
8221	Local treatment of post-extraction haemorrhage – initial visit (Excluding treatment of bleeding in the case of blood dyscrasias, e.g. haemophilia)	93.00				S
8223	Local treatment of post-extraction haemorrhage – each additional visit	63.00				S
8225	Treatment of septic socket – initial visit	93.00				S
8227	Treatment of septic socket – each additional visit	63.00				S
	Anaesthesia					
8141	Inhalation sedation or electronic analgesia - first quarter-hour or part-thereof	93.00				B
8143	Inhalation sedation or electronic analgesia – each additional quarter-hour or part thereof	47.00				B
	No additional fee/benefit to be charged for gases used in the case of items 8141 and 8143					
8144	Intravenous sedation	60.00				B
•8147	Use of own monitoring equipment in rooms for procedures performed under intravenous sedation	186.00				B
8145	Local anaesthetic, per visit	23.00				B
8499	The relevant DBN services shall apply to general anaesthetics for dental procedures					
	Professional consultations					
8106	Provision of a written treatment plan and quotation where prior authorisation is required by medical schemes	215.00				A
	This code is not applicable to routine enquiries to assess benefit available, or responses to enquiries of medical schemes to verify charges by dental practitioners. Also not applicable to furnishing copies of existing and necessary record					
	Professional visits					
8129	Additional fee/benefit for emergency treatment rendered outside normal working hours (including emergency treatment carried out at hospital) Not applicable where a practice offers an extended hours service as the norm.	315.00				B
8140	Fee for treatment at a venue other than the surgery, inclusive of hospital visits, treatment under general anaesthetic, home visits; per visit.	212.00				B
	Code 8140 may be applied concurrent with codes 8101 or 8104, but in accordance with rule 001.					
	Drugs, medicaments and materials					
8183	Intra-muscular or sub-cutaneous injection therapy, per injection	60.00				B
	(Not applicable to local anaesthetic)					
8220	Use of suture provided by practitioner	Rule 013				
8310	Supply of bleaching materials	Rule 013				
	Miscellaneous services					
8105	Appointment not kept – per half-hour	129.00				

• = New Code * = Revised Code

	(By arrangement with patient)					
8109	Infection control, per dentist, per hygienist, per dental assistant, per visit	16.00				B
	Code 8109 includes the provision by the dentist of new rubber gloves, masks, etc. for each patient					
8110	Provision of heat or vapour sterilized and wrapped instrumentation at the consulting rooms	52.00				S
	(Applicable mostly to surgical procedures involving incisions and suturing)					
8167	Treatment of hypersensitive dentine, per visit	99.00				B
8170	Minor occlusal adjustment	294.00				B
	(Not applicable to adjustment of restorations placed as part of a current treatment plan)					
8171	Mouth protectors	124.00		+L		B
8304	Rubber dam, per arch	104.00				B

II. ORAL PATHOLOGISTS

PREAMBLE

See Rule 012

In cases where services are not listed in this schedule, the appropriate fee(s) listed in the medical schedule(s) for pathologists shall be charged and the relevant fee/benefit in the medical schedule(s) must be indicated

II ORAL PATHOLOGISTS

		N$				
Code	Procedure description	DBN	Notes		MP	TC
9201	Consultation at rooms	238.00				
9203	Consultation at hospital, nursing home or house	273.00				
9205	Subsequent consultation	178.00				
9207	Night consultation	388.00				

III. SPECIALIST PROSTHODONTISTS

I SPECIALIST PROSTHODONTISTS
(M) See Rule 009

		N$				
Code	Procedure description	DBN	Notes		MP	TC
					MD	BK
	A. DIAGNOSTIC PROCEDURES					
8501	Consultation	238.00				A
8107	Intra-oral radiographs, per film	82.00				B
8108	Maximum for 8107	660.00				B
8113	Occlusal radiographs	129.00				B
8114	Hand-wrist radiograph	339.00				A
8115	Extra-oral radiograph, per film (i.e. Panoramic, cephalometric, PA)	339.00				B

• = New Code * = Revised Code

8811	Tracing and analysis of extra-oral film	39.00				B
8117	Study models - unmounted	93.00		+L		B
8119	Study models - mounted on adjustable articulator	238.00		+L		B
8121	Diagnostic photographs, per photograph	93.00				B
8503	Occlusal analysis on adjustable articulator	486.00				A
8505	Pantographic recording	710.00				A
8507	Examination, diagnosis and treatment planning	486.00				A
8506	Detailed clinical examination, records, radiographic interpretation, diagnosis, treatment planning and case presentation	785.00				A
	Code 8506 is a separate procedure from 8507 and is applicable to craniomandibular disorders, implant placement or orthognathic surgery where extensive restorative procedures will be required					
(M)	In the case of treatment planning requiring the combined services of a Prosthodontist and/or Orthodontist and/or a Maxillo-Facial and Oral Surgeon, Modifier 8009 (75%) may be applied to the fee charged by each specialist					
8508	Electrognathographic recording	761.00				A
8509	Electrognathographic recording with computer analysis	1 266.00				A
8510	Appointment not kept - per half-hour (By arrangement with patient)	193.00				
	B. PREVENTIVE PROCEDURES					
8711	Oral hygiene instruction	294.00				B
	The patient must be informed prior to the service being rendered that a fee will be levied for oral hygiene instruction					
8713	Oral hygiene evaluation	141.00				B
8155	Polishing only (including removal of plaque) - complete dentition	129.00				B
8159	Scaling and polishing	238.00				B
	Where item 8159 is applied, Item 8155 can not be charged					
8161	Topical application of fluoride preparations - complete dentition (Excluding scaling and/or polishing)	129.00				B
8163	Fissure sealant, per tooth	82.00			T	B
	Chargeble to a maximum of two teeth per quadrant					
8165	Application of fluoride using laboratory processed applicators	152.00		+L		B
8167	Treatment of hypersensitive dentine, per visit	99.00				B
8171	Mouth protectors	129.00		+L		B

	C. TREATMENT PROCEDURES					
	Emergency treatment					
8511	Emergency treatment for relief of pain (where no other tariff item is applicable	305.00				B
8513	Emergency crown (Not applicable to temporary crowns placed during routine crown and bridge preparations)	496.00		+L	T	A
8515	Recementing of inlay, crown or bridge, per abutment	191.00			T	B
8517	Re-implantation of an avulsed tooth, including fixation as required	511.00		+L	T	S
	Provisional treatment					
8521	Provisional splinting – extracoronal wire, per sextant	259.00				A
8523	Provisional splinting – extracoronal wire plus resin, per sextant	596.00				A
8527	Provisional splinting - intracoronal wire or pins or cast bar, plus amalgam or resin, per dental unit included in the splint	191.00		+L		A
*8529	Provisional crown Crown utilized as an interim restoration of at least six months during restorative treatment to allow adequate time for healing or completion of other procedures. This includes, but is not limited to, changing vertical dimension, completing periodontal therapy or cracked tooth syndrome. This is not to be used as a temporary crown for a routine prosthetic restoration	476.00		+L	T	A
8530	Preformed metal crown	414.00			T	A

	Occlusal adjustment					
8551	Major occlusal adjustment	1 397.00				A
	This procedure can not be carried out without study models mounted on an adjustable articulator					
8553	Minor occlusal adjustment	445.00				A
	Ceramic and/or resin bonded inlays and veneers:					
	In some of the procedures below (e.g. Direct hybrid inlays) +L may not apply.					
8554	Bonded veneers	1 696.00		+L	T	I
8555	One surface	1 225.00		+L	T	A
8556	Two surfaces	1 534.00		+L	T	A
8557	Three surfaces	2 379.00		+L	T	A
8558	Four or more surfaces	2 379.00		+L	T	A
8560	Cost of ceramic block	Rule 013			T	A
	Applicable to computer generated prosthesis only					
	Gold foil restorations					
8561	Class I and Class VI	1 279.00			T	A
8563	Class V	1 496.00			T	A
8565	Class III	1 967.00			T	A
	Gold restorations					
8571	One surface	886.00		+L	T	A
8572	Two surfaces	1 279.00		+L	T	A
8573	Three surfaces	1 980.00		+L	T	A
8574	Four or more surfaces	1 980.00		+L	T	A
8577	Pin retention	294.00			T	A
	Posts and copings					
8581	Single post	496.00		+L	T	A
8582	Double post	711.00		+L	T	A
8583	Triple post	886.00		+L	T	A
8587	Copings	407.00		+L	T	A
8589	Cast core with pins	698.00		+L	T	A
	Preformed posts and cores					
8591	Core build-up, including any pins/	486.00			T	B
	Refers to building up of anatomical crown when restorative crown will be placed, whether or not pins are used					
8593	Prefabricated post and core in addition to crown Core is built around a prefabricated post(s).	528.00			T	B
8596	Cost of posts	Rule 013			T	A
*	Applicable to pre-fabricated noble metal, ceramic, iridium and pure titinium posts					
	Implants					
8592	Osseo-integrated abutment restoration, per abutment	2 969.00		+L	T	A
8600	Cost of implant components	Rule 013				
8590	Periodic maintenance of existing implant prosthesis, per abutment	191.00			T	A
9190	Exposure of a single osseo-integrated implant and placement of a transmucosal element	704.00				S

• = New Code * = Revised Code

9191	Exposure of a second osseo-integrated implant and placement of a transmucosal element in the same jaw	531.00				S
9192	Exposure of a third and subsequent osseo-integrated implant in the same jaw, per implant	357.00				S
	Connectors					
8597	Locks and milled rests	200.00		+L	T	A
8599	Precision attachments	486.00		+L	T	A
	Crowns					
8601	Cast three-quarter crown	2 476.00		+L	T	A
8603	Cast gold crown	2 476.00		+L	T	A
8605	Acrylic veneered gold crown	2 476.00		+L	T	A
8607	Porcelain jacket crown	2 476.00		+L	T	A
8609	Porcelain veneered metal crown	2 476.00		+L	T	A
	Bridges					
	(Retainers as above)					
8611	Sanitary pontic	1 496.00		+L	T	A
8613	Posterior pontic	1 827.00		+L	T	A
8615	Anterior pontic	1 980.00		+L	T	A
	Resin bonded retainers					
8617	Per abutment	1 279.00		+L	T	A
	Per pontic (see 8611, 8613, 8615					
8618	Resin bonding for restorations	164.00				
	Applicable to any metal restorations, crowns or conventional bridges, per abutment except Maryland type bridges					
	Conservative treatment for temporomandibular joint dysfunction					
8625	Bite plate for TMJ dysfunction	739.00		+L		B
8621	First visit for treatment of TMJ dysfunction	339.00				S
8623	Follow-up visit for TMJ dysfunction	178.00				S
	The number of visits and charge therefore depends on the relation between the practitioner and the patient, and the problems involved in the case					
	Endodontic and bleaching procedures, etc.					
	ROOT CANAL THERAPY					
	Procedure codes 8631, 8633 and 8644 include all X-rays and repeat visits					
8631	Root canal therapy, first canal	1 749.00			T	B
8633	Each additional canal	435.00			T	B
8634	Endodontic procedure on primary tooth	350.00				B
8636	Re-preparation of previously obturated canal, per canal	304.00			T	B
	BLEACHING					
(M)	Modifier 8002 is applicable to procedure codes 8325, 8327					
8325	Bleaching of non-vital teeth, per tooth as a separate procedure	328.00			T	A
8327	Each additional visit for bleaching of non-vital tooth as a separate procedure	152.00				A
	A maximum of two additional visits may be charged					
8308	Bleaching of vital teeth, per arch, per visit	1 095.00				A
	The unpredictability and lack of permanence of this procedure should be pointed out, and alternative procedures discussed with the patient					

	OTHER ENDODONTIC PROCEDURE					
8635	Apexification of root canal, per visit	288.00			T	B
8637	Hemisection of a tooth, resection of a root or tunnel preparation (as an isolated procedure)	958.00			T	A
9015	Apicectomy including retrograde root filling where necessary - anterior teeth	688.00			T	S
9016	Apicectomy including retrograde root filling where necessary - posterior teeth	1918.00			T	S
8640	Removal of fractured post or instrument from root canal	511.00			T	B
	Prosthetics (Removable)					
8641	Complete upper and lower dentures without primary complications	4 955.00		+L		B
8643	Complete upper and lower dentures without major complications	6 430.00		+L		B
8645	Complete upper and lower dentures with major complications	7 907.00		+L		B
8647	Complete upper or lower denture without primary complications	3 465.00		+L		B
8649	Complete upper or lower denture without major complications	3 959.00		+L		B
8651	Complete upper or lower denture with major complications	4 452.00		+L		B
8661	Diagnostic dentures (inclusive of tissue conditioning treatment	3 959.00		+L		A
8662	Remounting and occlusal adjustment of dentures	561.00		+L		B
8663	Chrome cobalt base or gold base for full denture (extra charge	1 190.00		+L		I
8664	Remount of crown or bridge for extensive prosthetics	569.00				A
8665	Re-base, per denture	803.00		+L		B
8667	Soft base, per denture (heat cured)	1 190.00		+L		B
8668	Tissue conditioner, per denture	294.00				B
8669	Intra-oral reline of complete or partial denture	439.00				B
8671	Metal (e.g. Chrome cobalt or gold) partial denture	3 959.00		+L		B
8672	Additional fee/benefit for altered cast technique for partial denture	153.00		+L		B
8674	Additive partial denture	1 795.00		+L		B
8679	Repairs	200.00		+L		B
8273	Additional fee/benefit where impression is required for 8679	93.00		+L		B
8275	Adjustment of denture (After six months or for a patient of another practitioner)	93.00				B
	D. MAXILLO-FACIAL PROSTHODONTIC PROSTHESES					
	Where "+D" appears the practitioner will charge the relevant fee/benefit for the denture in the Prosthodontic Schedule plus the fee/benefit indicated					
	Maxillary prostheses					
9101	Surgical obturator - Modified denture	294.00		+L		
9102	Surgical obturator - continuous base	803.00		+L		
9103	Surgical obturator - split base	1 990.00		+L		
9104	Interim obturator on existing denture	1 785.00		+L		
9105	Interim obturator on new denture	5 549.00		+L		
9106	Definitive obturator - open/ hollow box	1 795.00		+D		
9107	Definitive obturator - silicone glove	2 085.00		+D		
	Mandibular resection prostheses					
9108	Prosthesis with guide flange	4 255.00		+L		
9109	Prosthesis without guide flange	3 959.00		+L		
9110	Prosthesis - Palatal augmentation	802.00		+D		
	Glossal resection prostheses					
9111	Simple prosthesis.	1 664.00		+D		
9112	Complex prosthesis	2 493.00		+D		

	Radiotherapy appliances					
9113	Carriers - simple	1 795.00		+L		
9114	Carriers - complex	4 955.00		+L		
9115	Shields - simple	1,795.00		+L		
9116	Shields - complex	4 955.00		+L		
9117	Cone locators	1 795.00		+L		
	Chemotherapy appliances					
9118	Chemotherapeutic agent carriers	1 795.00		+L		
	Cleft palate prostheses					
8855	Consultation and therapy at hospital/ nursing home/ residence	407.00				
8856	Subsequent consultation	200.00				
8857	Weekly maximum	1 400.00				
	Neonatal prostheses					
9119	Passive presurgical prosthesis/ Neonatal feeding aid/ Passiewe pre-chirurgiese prostese	1,592.00		+L		
9120	Active presurgical orthopaedic appliance - minor	1,592.00		+L		
9121	Active presurgical orthopaedic appliance - moderate	2,397.00		+L		
9122	Active presurgical orthopaedic appliance - severe	3 959.00		+L		
9123	Active presurgical orthopaedic appliance adjustment	200.00				
	Intermediate/Definitive prostheses					
9125	Speech aid/obturator with palatal modification	803.00		+D		
9126	Speech aid/obturator with velar modification	1 795.00		+D		
9127	Speech aid/ obturator with pharyngeal modification	3 959.00		+D		
9128	Speech aid/obturator adjustment	200.00				
9129	Speech aid/obturator surgical prosthesis	1 592.00		+L		
	Speech appliances					
9130	Palatal lift	803.00		+D		
9131	Palatal stimulating	1 795.00		+D		
9132	Speech bulb	3 959.00		+D		
9133	Adjustments	200.00				
9134	Other (By arrangement)	na		+L		
	Extra-oral appliances					
9135	Auricular prosthesis - simple	4 955.00		+L		
9136	Auricular prosthesis - complex	6 430.00		+L		
9137	Nasal prosthesis - simple	4 955.00		+L		
9138	Nasal prosthesis - complex	6 430.00		+L		
9139	Ocular prosthesis - conformer	1 795.00		+L		
9140	Ocular prosthesis using modified stock appliance	4 454.00		+L		
9141	Ocular prosthesis using custom appliance	6 430.00		+L		
9142	Orbital prosthesis - simple (excluding ocular section	4 454.00		+L		
9143	Orbital prosthesis - complex (excluding ocular section	6 430.00		+L		
9144	Combination facial prostheses - small	na		+L		
9145	Combination facial prostheses - medium	na		+L		
9146	Combination facial prostheses - large	na		+L		
9147	Combination facial prostheses - complex	na		+L		
9148	Other body prostheses - simple	4 454.00		+L		

• = New Code * = Revised Code

9149	Other body prostheses - complex	6 430.00		+L		
9150	Surgical facial prostheses - simple	3 465.00		+L		
9151	Surgical facial prostheses - complex	4 454.00		+L		
9152 (M)	Additional prostheses (from mould at time of first prosthesis)	M 8006		+L		
9153 (M)	Replacement prosthesis (from original mould)	M 8006		+L		
9155	Cranial prosthesis	1 795.00		+L		
	Custom implants					
9156	Cranial - acrylic, elastomeric, metallic	4,125.00		+L		
9157	Facial - simple	1 112.00		+L		
9158	Facial - complex	2,230.00		+L		
9159	Ocular - custom made	1,112.00		+L		
9160	Body - special prosthesis	4 955.00		+L		
	Surgical appliances					
9161	Splints - simple	486.00		+L		
9162	Splints - complex	1,795.00		+L		
9163	Templates - simple	486.00		+L		
9164	Templates - complex	1,795.00		+L		
9165	Conformers - simple	486.00		+L		
9166	Conformers - complex	1,795.00		+L		
	Trismus appliances					
9167	Trismus appliance - simple	200.00		+L		
9168	Trismus appliance - complex	1,795.00		+L		
9169	Orthoses (for paralysed patients)	3 959.00		+L		
9170	Facial palsy appliances	1,189.00		+D		
9171	Oral splints (per commissure	491.00		+L		
9172	Dynamic oral retractors (per arm	491.00		+L		
9173	Hand splints	na		+L		
9174	Other	na		+L		
	Attendance in theatre					
9175	Attendance in theatre, per hour	656.00				

	IV. SPECIALISTS IN ORAL MEDICINE AND PERIODONTICS
	PREAMBLE
(1)	The scheduled fees for diagnostic procedures may be charged irrespective of whether treatment is accepted or not
(2)	The expenses appurtenant to diagnostic tests, laboratory procedures (unless routinely charged to the patient by the laboratory), special materials, medicaments, etc., shall be charged over and above the fee for treatment (See Rule 013)
(3) (M)	If the extent of a procedure carried out is less than that specified in the tariff of fees, or if multiple procedures are carried out at a single visit and the value of the time factor is consequently reduced, the specialist may at his discretion charge a reduced fee or reduced fees as per modifiers. (See Rule 011)
(4)	Fees for surgical procedures include any postsurgical complications not exceeding three months
(5)	The fee payable to a general practitioner assistant shall be calculated as 15% of the fee of the practitioner performing the operation, with the indicated minimum (See Modifier 8007); the fee for an assistant who is a specialist in oral medicine and periodontics shall be 33 1/3 % of the fee for the procedure. The patient must be informed beforehand that another dentist will be assisting at the operation and that a fee will be payable to the assistant. The assistant's name must appear on the invoice rendered to the patient

• = New Code * = Revised Code

IV	SPECIALISTS IN ORAL MEDICINE AND PERIODONTICS (M) See Rule 009					
			N$			
Code	Procedure description	DBN			MP	TC
	DIAGNOSTIC PROCEDURES					
	Codes 8701, 8703, 8705 and 8707 cannot be charged at one and the same visit					
8701	Consultation	238.00				A
	A periodontal consultation comprises a reasonably detailed examination and presentation and explanation of the findings to enable the patient to make a decision as to future treatment					
8107	Intra-oral radiographs, per film	82.00				B
8108	Maximum for 8107	661.00				B
8113	Occlusal radiographs	129.00				B
8114	Hand-wrist radiograph	339.00				A
8115	Extra-oral radiograph, per film (i.e. panoramic, cephalometric, PA)	339.00				B
8811	Tracing and analysis of extra-oral film	39.00				B
8117	Study models - unmounted	93.00		+L		B
8119	Study models - mounted on adjustable articulator	238.00		+L		B
8140	Fee for treatment at a venue other than the surgery, inclusive of hospital visits, treatment under general anaesthetic, home visits; per visit	212.00				B
8703	Detailed clinical examination, records, radiographic interpretation, diagnosis, treatment planning and case presentation	803.00				A
	Code 8703 is always a separate procedure from code 8701 and comprises inspection, percussion, probing and other diagnostic procedures and the systematic recording of every important feature in order to permit correct treatment planning					
8705	Periodic re-examination	238.00				A
8706	Appointment not kept - per half-hour (By arrangement with patient)	193.00				
8707	Periodontal screening	238.00				B
	A periodontal screening consists of the measurement and recording of a plaque index, a bleeding index, probing depths, a periodontal disease index, a microbiological assay and/or gingival crevicular fluid assay					
8711	Oral hygiene instruction	294.00				B
	The patient must be informed prior to the service being rendered that a fee will be levied for oral hygiene instruction					
8713	Oral hygiene evaluation	141.00				B
	(If oral hygiene re-instruction is necessary, only Item 8711 shall apply)					
8714	Full mouth clinical plaque removal	200.00				B
8715	Scaling	406.00				B
8721	Occlusal adjustment per visit	447.00				A
8723	Provisional splinting - extracoronal wire, per sextant	407.00		+L		A
8725	Provisional splinting - extracoronal wire plus resin, per sextant	591.00		+L		A
8727	Provisional splinting – intracoronal wire or pins or cast bar, plus amalgam or resin, per dental unit included in the splint	191.00		+L		A

• = New Code * = Revised Code

	TEMPOROMANDIBULAR JOINT PROCEDURES					
8625	Bite plate for TMJ dysfunction	739.00		+L		B
	SURGICAL PROCEDURES					
8731	Periodontal abscess - treatment of acute phase (with or without flap procedure)	352.00				A
8737	Root planing with or without periodontal curettage, per quadrant	802.00				A
8739	Root planing with or without periodontal curettage, per sextant	638.00				A
8741	Gingivectomy-gingivoplasty, per quadrant	1 055.00				A
8743	Gingivectomy-gingivoplasty, per sextant	837.00				A
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, apicectomy, clinical crown lengthening, per quadrant	2 395.00				A
8751	As item 8749, per sextant	1 980.00				A
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, apicectomy, clinical crown lengthening, per quadrant	2 965.00				A
8755	As item 8753, per sextant	2 404.00				A
*	NOTES 1. Each root resection, tooth hemisection, muco-gingival procedure, wedge resection, clinical crown lengthening and apicectomy shall be deemed to be one procedure					
	2. Where a bone regeneration/ repair procedure is included within a flap operation, Item 8766 shall apply in addition to the Item for the flap operation					
8756	Flap operation with bone removal to increase the clinical crown length of a single tooth (as an isolated procedure)	1 457.00				A
8757	Frenectomy	1 145.00				A
8758	Surgical exposure of impacted or unerupted teeth for orthodontic reasons	1 599.00				A
8759	Pedicle flapped graft e.g. lateral sliding double papilla, rotated and similar (as an isolated procedure)	1 098.00				A
8762	Masticatory mucosal autograft and subepithelial connective tissue extending across more than four teeth (isolated procedure)	1 791.00		+L		A
8763	Wedge resection (as an isolated procedure)	698.00			T	A
8760	Apicectomy including retrograde filling where necessary - anterior teeth	958.00			T	S
8764	Apicectomy including retrograde filling where necessary, posterior teeth	1 918.00			T	S
8765	Hemisection of a tooth, resection of a root or tunnel preparation (as an isolated procedure)	958.00			T	A
8766	Bone regenerative/ repair procedure excluding cost of regenerative material as part of a flap operation as described in Items 8749, 8751, 8753 and 8755, per procedure	573.00				A
8770	Cost of bone regenerative/repair material	Rule 013				
8768	Any other periodontal procedure involving a single tooth	698.00			T	A
8979	Harvesting of autogenous grafts (intra-oral)	376.00				S
9008	Alveolar ridge augmentation across 1 to 2 adjacent tooth sites	1,181.00		+L		S
9009	Alveolar ridge augmentation across 3 or more tooth sites	1,769.00		+L		S
9010	Sinus lift procedure	3,237.00		+L		S

	IMPLANT PROCEDURES					
9182	Placement of endosteal implant, per implant	1 495.00		+L		S
9183	Placement of a single osseo-integrated implant per jaw	1 910.00				S
9184	Placement of a second osseo-integrated implant in the same jaw	1 431.00				S
9185	Placement of a third and subsequent osseo-integrated implant in the same jaw, per implant	956.00				S
9189	Cost of implants	Rule 013				S
9190	Exposure of a single osseo-integrated implant and placement of a transmucosal element	704.00				S
9191	Exposure of a second osseo-integrated implant and placement of a transmucosal element in the same jaw	531.00				S
9192	Exposure of a third and subsequent osseo-integrated implant in the same jaw, per implant	357.00				S
8761	Masticatory mucosal autograft and subepithelial connective tissue autograft extending across not more than four teeth (isolated procedure)	1 293.00		+L		A
8767	Bone regenerative/ repair procedure at a single site	1 484.00				A
	(Excluding cost of regenerative material – see code 8770)					
8769	Subsequent removal of membrane used for guided tissue regeneration procedure	698.00				A
	Codes 8761, 8767 and 8769 to be used only as part of implant surgery					
	ORAL MEDICAL PROCEDURES					
8781	Consultation, examination, diagnosis and treatment of oral diseases, pathological conditions of the surrounding tissues, temporomandibular joint disorders or myofascial pain-dysfunction: Straight forward case	238.00				S
8782	Consultation, examination, diagnosis and treatment of oral diseases, pathological conditions of the surrounding tissues, temporomandibular joint disorders or myofascial pain dysfunction: Complex case	417.00				S
8783	Subsequent consultation for same disease/condition	178.00				S
8785	Biopsy - incisional/excisional (e.g. epulis)	496.00				S
8786	Surgical treatment of soft tissue tumours (e.g. epulis	856.00				S
8787	Any other procedure connected with the practice of oral medicine	251.00				S

	V. SPECIALIST ORTHODONTISTS
	PREAMBLE
(1)	Where an invoice refers to orthodontic services, a statement containing the following information shall accompany the first invoice to the member of the scheme/ (a) the code number of the envisaged treatment (b) a plan of treatment indicating the following/ (i) the total tariff that would be charged by the practitioner for the treatment (ii) the duration of the treatment (iii) the initial primary tariff payable by the member; and (iv) the monthly tariff which the member must pay
(2)	The fee for corrective therapy (i.e. codes 8861 to 8888) is an inclusive fee and no additional fees may be charged for additional visits (Code 8803), oral hygiene instructions/re-evaluation (Codes 8151 and 8153), scaling and/or polishing (Codes 8155 and 8159) or topical application of fluoride (Code 8161) until the treatment is completed.
(3)	When partial fixed appliance therapy or preliminary treatment (8858, 8861, 8865 or 8866) is followed by full fixed appliance treatment (8873 to 8888) the fee initially charged for 8858, 8861, 8865 or 8866 is deducted from the full fixed appliance fee and the remainder then becomes the fee charged for the second stage of full fixed appliance therapy
(4)	If more than one of the stages of treatment of a multiphase treatment procedure is carried out by the same orthodontist, then the total fee should not exceed the fee laid down by the original classification at current values, save in exceptional circumstances, e.g. cleft palate treatment
(5)	The fees for services covered under the heading 'Fixed appliance therapy' (items 8861 and 8865 to 8887) shall be charged over the period of treatment in a manner to be determined by the individual orthodontist
(6)	If treatment is discontinued prior to its completion, the balance of the fee shall be assessed on the basis of the services rendered up to the time of termination
(7) (M)	There are no specific codes for orthodontic treatment in the general practitioners' schedule, and the general practitioner must refer to the specialist orthodontists schedule. The codes for the treatment must be quoted together with Modifier 8004 (See Rules 009 and 011). This denotes that a general practitioner is delivering the treatment and the fee is calculated as up to two- thirds of the appropriate specialists fee. Where "+L" is denoted this can be added on to the two-thirds fee. If "+L" is not denoted then this is incorporated in the appropriate two-thirds fee and cannot be added to the invoice

V	SPECIALIST ORTHODONTISTS (M) See Rule 009					
		N$				
Code	Procedure description	DBN			MP	TC
	CONSULTATIONS					
8801	First consultation	238.00				A
8803	Subsequent consultation, retention and/ or post-treatment consultation	178.00				A
8805	Appointment not kept - per half-hour (By arrangement with patient)	193.00				
	RECORDS AND INVESTIGATIONS					
8107	Intra-oral radiographs, per film	82.00				B
8108	Maximum for 8107	661.00				B
8113	Occlusal radiograph	129.00				B
8114	Hand-wrist radiograph	339.00				A
8115	Extra-oral radiograph, per film (i.e. panoramic, cephalometric, PA)	339.00				B
8811	Tracing and analysis of extra-oral film	39.00				B
8117	Study models - unmounted	93.00		+L		B

• = New Code * = Revised Code

8119	Study models - mounted on adjustable articulator	238.00		+L		B
8121	Diagnostic photographs, per photograph	93.00				B
8837	Diagnosis and treatment planning	141.00				A
8839	Orthodontic diagnostic setup	298.00				A
	ORTHOGNATHIC SURGERY AND TREATMENT PLANNING					
(M)	In the case of treatment planning requiring the combined services of a Prosthodontist and/or Orthodontist and/or a Maxillo-Facial and Oral Surgeon, Modifier 8009 (75%) may be applied to the fee charged by each specialist					
8840	Treatment planning for orthognathic surgery	1 035.00		+L		A
	RETAINERS, REPAIRS AND/OR REPLACEMENTS					
8846	Removable: Repairs	204.00		+L		A
8847	Removable: Replacement	698.00		+L		A
8848	Fixed: Repair or replacement per unit (As a result of the patient's negligence)	298.00				A
8849	Retainer	698.00		+L		A
	CORRECTIVE THERAPY					
	Treatment of MPDS					
8850	First consultation	339.00				A
8851	Subsequent consultation	178.00				A
8852	Bite plate for TMJ dysfunction	739.00		+L		B
	Occlusal adjustment					
8853	Major occlusal adjustment	1 397.00				A
8854	Minor occlusal adjustment	445.00				A
	Cleft palate therapy					
8855	Consultation and therapy at hospital, nursing home, or residence	407.00				S
8856	Subsequent consultation	200.00				S
8857	Weekly maximum	1 400.00				S
	Neonatal prostheses					
9119	Passive presurgical prosthesis/ Neonatal feeding aid	1 592.00		+L		S
9120	Active presurgical orthopaedic appliance - minor	1 592.00		+L		S
9121	Active presurgical orthopaedic appliance - moderate	2 355.00		+L		S
9122	Active presurgical orthopaedic appliance - severe	3 961.00		+L		S
9123	Active presurgical orthopaedic appliance - adjustment	200.00				S
	NOTE Subsequent treatment as per schedule					
	Removable appliance therapy					
8862	Removable (single	2 470.00		+L		A
8863	Removable (per additional	1 247.00		+L		A
	(Code 8862 may only be charged once per malocclusion. A maximum of two additional removable appliances per treatment plan may be charged					
	Functional appliance therapy/					

• = New Code * = Revised Code

	A removable functional appliance is an appliance with no fixed dental component which is designed to harness the forces generated by the muscles of mastication and the associated soft tissues of the oro-facial region. This appliance incorporates components which act on both the maxillary and mandibular arches and should be differentiated from a simple removable appliance including appliances incorporating an anterior and posterior bite plane					
8858	Functional appliance	4 461.00		+L		A
	If additional functional appliances are required, +L can be charged but no further fee/benefit					
	Fixed appliance therapy/					
	Partial fixed appliance therapy - Preliminary treatment					
	The intention of this phase in treatment is to intercept and modify the development of skeletal, dental and functional components of developing malocclusion usually in the mixed dentition The application of codes 8865 and/or 8866 requires the use of fixed bands and/or brackets as a major component of the appliances/					
8865	Maxillary or mandibular arch	7 914.00				A
8866	Combined maxillary and mandibular arch	10 878.00				A
8861	Minor fixed appliance	2 965.00				A
	Comprehensive fixed appliance therapy					
	This form of therapy requires the placement of fixed bands and or brackets on the majority of teeth within each arch and the subsequent placement of active arch wires to treat the case through to completion of active treatment excluding the retention phase					
	SINGLE ARCH TREATMENT					
8867	Mild	8 507.00				A
8868	Moderate	10 491.00				A
8869	Severe	12 271.00				A
	COMBINED MAXILLARY AND MANDIBULAR ARCH THERAPY					
	CLASS I MALOCCLUSIONS					
8873	Mild	15 568.00				A
8875	Moderate	19 105.00				A
8877	Severe	22 271.00				A
8879	Severe plus complications	25 029.00				A
	CLASS II AND III MALOCCLUSIONS					
8881	Mild	22 271.00				A
8883	Moderate	25 029.00				A
8885	Severe	28 101.00				A
8887	Severe plus complications	31 662.00				A
	Lingual orthodontics					
	This form of therapy requires the placement of bands and or brackets on the lingual aspect of the majority of teeth within at least one arch and must include the placement of active arch wires					
	SINGLE ARCH TREATMENT					

8841	Mild	15 986.00				A
8842	Moderate	18 786.00				A
8843	Severe	21 402.00				A
	COMBINED MAXILLARY AND MANDIBULAR ARCH THERAPY					
	CLASS I MALOCCLUSIONS					
8874	Mild	30 491.00				A
8876	Moderate	35 702.00				A
8878	Severe	40 518.00				A
8880	Severe plus complications	44 956.00				A
	CLASS II AND III MALOCCLUSIONS					
8882	Mild	37 418.00				A
8884	Moderate	41 636.00				A
8886	Severe	46 368.00				A
8888	Severe plus complications	51 602.00				A
	OTHER ORTHODONTIC SERVICES					
8890	Monthly payment for treatment (Refer to code number of treatment)	By arrangement				A
8891	Re-negotiated fee for transfer cases	By arrangement				
8892	Re-treatment	By arrangement				

	VI. SPECIALIST MAXILLO- FACIAL AND ORAL SURGEONS
	PREAMBLE
	(See Rule 011)
1. (M)	If extractions (codes 8201 and 8202) are carried out by specialists in maxillo- facial and oral surgery, the fees shall be equal to the appropriate tariff fee plus 50 per cent (See Modifier 8002)
2. (M)	The fee for more than one operation or procedure performed through the same incision shall be calculated as the fee for the major operation plus the tariff fee for the subsidiary operation to the indicated maximum for each such subsidiary operation or procedure (See Modifier 8005)
3. (M)	The fee for more than one operation or procedure performed under the same anaesthetic but through another incision shall be calculated on the tariff fee for the major operation plus: 75% for the second procedure/operation (Modifier 8009) 50% for the third and subsequent procedures/operations (Modifier 8006)
	This rule shall not apply where two or more unrelated operations are performed by practitioners in different specialities, in which case each practitioner shall be entitled to the full fee for his operation
	If, within four months, a second operation for the same condition or injury is performed, the fee for the second operation shall be half of that for the first operation
	The fee for an operation shall, unless otherwise stated, include normal post-operative care for a period not exceeding four months. If a practitioner does not himself complete the post-operative care, he shall arrange for it to be completed without extra charge: provided that in the case of post-operative treatment of a prolonged or specialised nature, such fee as may be agreed upon between the practitioner and the scheme may be charged
4. (M)	The fee payable to a general practitioner assistant shall be calculated as 15% of the fee of the practitioner performing the operation, with the indicated minimum (See Modifier 8007). The assistant's fee payable to a maxillo- facial and oral surgeon shall be calculated at 33,33% of the appropriate scheduled fee (Modifier 8001). The assistant's name must appear on the invoice rendered to the patient
5. (M)	The additional fee to all members of the surgical team for after hours emergency surgery shall be calculated by adding 25% to the fee for the procedure or procedures performed (8008)
6.	In cases where treatment is not listed in this schedule for general practitioners or specialists, the appropriate fee listed in the medical schedule(s) shall be charged, and the relevant medical tariff item must be indicated (See Rule 012)

VI	SPECIALIST MAXILLO- FACIAL AND ORAL SURGEONS (M) See Rule 009					
		N$				
Code	Procedure description	DBN	Notes		MP	TC
	CONSULTATIONS AND VISITS					
8901	Consultation at consulting rooms	238.00				S
8902	Detailed clinical examination, radiographic interpretation, diagnosis, treatment planning and case presentation	803.00				S
	Code 8902 is a separate procedure from code 8901 and is applicable to craniomandibular disorders, implant placement and orthognathic and maxillofacial reconstruction					
8903	Consultation at hospital, nursing home or house	273.00				S
8904	Subsequent consultation at consulting rooms, hospital, nursing home or house	178.00				S
8905	Weekend visits and night visits between 18h00 - 07h00 the following day	388.00				S
8907	Subsequent consultations, per week, to a maximum of	445.00				S
	Subsequent consultation" shall mean, in connection with items 8904 and 8907, a consultation for the same pathological condition provided that such consultation occurs within six months of the first consultation					
	INVESTIGATIONS AND RECORDS					
8107	Intra-oral radiographs, per film	82.00				B
8108	Maximum for 8107	743.00				B
8113	Occlusal radiographs	129.00				B
8114	Hand-wrist radiograph	339.00				A
8115	Extra-oral radiograph, per film (i.e. panoramic, cephalometric, PA)	339.00				B
8811	Tracing and analysis of extra-oral film	39.00				B
8117	Study models - unmounted	93.00		+L		B
8119	Study models - mounted on adjustable articulator	238.00		+L		B
8121	Diagnostic photographs - per photograph	93.00				B
8917	Biopsies – intra-oral	496.00				S
8919	Biopsy of bone - needle	856.00				S
8921	Biopsy of bone - open	1 406.00				S
	ORTHOGNATHIC SURGERY AND TREATMENT PLANNING					
(M)	In the case of treatment planning requiring the combined services of a Prosthodontist and/or Orthodontist and/or a Maxillo-Facial and Oral Surgeon, Modifier 8009 (75%) may be applied to the fee charged by each specialist					
8840	Treatment planning for orthognathic surgery	1 035.00		+L		A
	REMOVAL OF TEETH					
	Modifier 8002 is applicable to codes 8201 and 8202					
	Extractions during a single visit					
8201	Single tooth	129.00			T	B

• = New Code * = Revised Code

VI	SPECIALIST MAXILLO- FACIAL AND ORAL SURGEONS (M) See Rule 009					
		N$				
Code	Procedure description	DBN	Notes		MP	TC
	Code 8201 is charged for the first extraction in a quadrant					
8202	Each additional tooth in the same quadrant	52.00			T	B
	Code 8202 is charged for each additional extraction in the same quadrant					
8957	Alveolotomy or alveolectomy - concurrent with or independent of extractions (per jaw)	1 172.00				S
8961	Auto-transplantation of teeth	1 918.00		+L		S
8931	Local treatment of post-extraction haemorrhage (excluding treatment of bleeding in the case of blood dyscrasias, e.g. haemophilia)	639.00				S
8933	Treatment of haemorrhage in the case of blood dyscrasias, e.g. hemophilia, per week	2 233.00				S
8935	Treatment of post-extraction septic socket where patient is referred by another registered person	169.00				S
*8937	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap, removal of bone and/or section of tooth Includes cutting of gingiva and bone, removal of tooth structure and closure Code 8220 is applicable when sutures are provided by practitioner (Rule 013)	590.00				S
	Removal of roots					
	Code 8220 is applicable when sutures are provided by practitioner (Rule 013)					
*8953	Surgical removal of residual tooth roots (cutting procedure) Includes cutting of gingiva and bone, removal of tooth structure and closure	856.00			T	S
*8955 (M)	Surgical removal of residual tooth roots (cutting procedure), each subsequent tooth Includes cutting of gingiva and bone, removal of tooth structure and closure (See Rule 011 and Notes 2 and 3)	na			T	S
	Unerupted or impacted teeth					
8941	First tooth	1 385.00			T	S
8943	Second tooth	744.00			T	S
8945	Third tooth	427.00			T	S
8947	Fourth and subsequent tooth	427.00			T	S

	DIVERSE PROCEDURES					
8908	Removal of roots from maxillary antrum involving Caldwell-Luc and closure of oral antral communication	2 914.00				S
8909	Closure of oral antral fistula - acute or chronic	2 233.00				S
8911	Caldwell-Luc procedure	877.00				S
8965	Peripheral neurectomy	1 918.00				S
8966	Functional repair of oronasal fistula (local flaps	2 668.00				S
8977	Major repairs of upper or lower jaw (i.e. by means of bone grafts or prosthesis, with jaw splintage	4 480.00				S
	(Modifiers 8005 and 8006 are not applicable in this instance. The full fee may be charged irrespective of whether this procedure is carried out concomitantly with procedure 8975 or as a separate procedure)					
8979	Harvesting of autogenous grafts (intra-oral)	376.00				S
•8962	Harvest iliac crest graft	785.00				S
•8963	Harvest rib graft	903.00				S
•8964	Harvest cranium graft	706.00				S
	CYSTS OF JAWS					
8967	Intra-oral approach	2 668.00				S
8969	Extra-oral approach	4 269.00				S
	NEOPLASMS					
8971	Surgical treatment of soft tissue tumours	856.00				S
8973	Surgical treatment of tumours of the jaws	4 269.00				S
8975	Hemiresection of jaw, with splintage of segments	4 483.00				S
	PARA-ORTHODONTIC SURGICAL PROCEDURES					
8981	Surgical exposure of impacted or unerupted teeth for orthodontic reasons	1 599.00			T	S
8983	Corticotomy – first tooth	1 275.00			T	S
8984	Corticotomy - adjacent or subsequent tooth	643.00			T	S
8985	Frenectomy	.1 172.00				S

	SURGICAL PREPARATION OF JAWS FOR PROSTHETICS					
8987	Reduction of mylohyoid ridges, per side	1 918.00		+L		S
8989	Torus mandibularis reduction, per side	1 918.00		+L		S
8991	Torus palatinus reduction	1 918.00		+L		S
8993	Reduction of hypertrophic tuberosity, per side	856.00		+L		S
	See procedure code 8971 for excision of denture granuloma					
8995	Gingivectomy, per jaw	1 708.00		+L		S
8997	Sulcoplasty/Vestibuloplasty	4 400.00		+L		S
9003	Repositioning mental foramen and nerve, per side	2 668.00		+L		S
9005	Total alveolar ridge augmentation by bone graft	4 483.00		+L		S
9007	Total alveolar ridge augmentation by alloplastic material	2 827.00		+L		S
9008	Alveolar ridge augmentation across 1 to 2 adjacent tooth sites	1,181.00		+L		S
9009	Alveolar ridge augmentation across 3 or more tooth sites	1,769.00		+L		S
9010	Sinus lift procedure	3,237.00		+L		S
	SEPSIS					
9011	Incision and drainage of pyogenic abscesses (intra-oral approach	546.00				S
9013	Extra-oral approach, e.g. Ludwig's angina	744.00				S
9015	Apicectomy including retrograde filling where necessary – anterior teeth	958.00			T	S
9016	Apicectomy including retrograde filling where necessary, posterior teeth	1 918.00			T	S
9017	Decortication, saucerisation and sequestrectomy for osteomyelitis of the mandible	3 956.00				S
9019	Sequestrectomy - intra-oral, per sextant and/or per ramus	856.00				S
	TRAUMA					
	Treatment of associated soft tissue injuries					
9021	Minor	958.00				S
9023	Major	2 026.00				S
9024	Dento-alveolar fracture, per sextant	958.00		+L		S
	Mandibular fractures					
9025	Treatment by closed reduction, with intermaxillary fixation	2 130.00				S
9027	Treatment of compound fracture, involving eyelet wiring	2 992.00				S
9029	Treatment by metal cap splintage or Gunning's splints	3 311.00		+L		S
9031	Treatment by open reduction with restoration of occlusion by splintage	4 908.00		+L		S
	Maxillary fractures with special attention to occlusion					
	When open reduction is required for Items 9035 and 9037, Modifier 8010 may be applied					S
9035	Le Fort I or Guerin fracture	2 999.00		+L		S
9037	Le Fort II or middle third of face	4 908.00		+L		S
9039	Le Fort III or craniofacial disjunction or comminuted mid-facial fractures requiring open reduction and splintage	7 045.00		+L		S
	Zygoma/Orbit/Antral - complex fractures					
9041	Gillies or temporal elevation	2 130.00				S
9043	Unstable and/or comminuted zygoma, treatment by open reduction or Caldwell-Luc operation	4 269.00				S
9045	Requiring multiple osteosynthesis and/ or grafting	6 400.00				S
	FUNCTIONAL CORRECTION OF MALOCCLUSIONS					

	For items 9047 to 9072 the full fee may be charged i.e. notes 2 and 3 (re Rule 011) will not apply					
9047	Operation for the improvement or restoration of occlusal and masticatory function, e.g. bilateral osteotomy, open operation (with immobilisation	8 955.00		+L		S
9049	Anterior segmental osteotomy of mandible (Köle	7 462.00		+L		S
9050	Total subapical osteotomy	14 748.00				S
9051	Genioplasty	4 269.00				S
9052	Midfacial exposure (for maxillary and nasal augmentation or pyramidal Le Fort II osteotomy	6 761.00				S
9055	Maxillary posterior segment osteotomy (Schukardt) - 1 or 2 stage procedure	7 462.00		+L		S
9057	Maxillary anterior segment osteotomy (Wassmund) - 1 or 2 stage procedure	7 462.00		+L		S
9059	Le Fort I osteotomy - one piece	14 045.00		+L		S
9062	Le Fort I osteotomy - multiple segments	17 914.00		+L		S
9060	Le Fort I osteotomy with inferior repositioning and inter positional grafting	15 762.00				S
9061	Palatal osteotomy	4 908.00				S
9063	Le Fort II osteotomy for correction of facial deformities or faciostenosis and post-traumatic deformities	17 932.00		+L		S
9065	Le Fort III osteotomy for correction of severe congenital deformities, viz. Crouzon's disease and malunited craniomaxillary disjunction	26 881.00		+L		S
•9066	Surgical assisted maxillary or mandibular expansion/ Chirurgies ondersteunde maksillêre of mandibulêre ekspansie	4,751.00				S
	This procedure is to expand the maxilla or mandible to facilitate orthodontic aligning of constricted dental arche					
9069	Functional tongue reduction (partial glossectomy	3 202.00				S
9071	Geniohyoidotomy	1 918.00				S
9072	Functional closure of the secoDBNry oro-nasal fistula and associated structures with bone grafting (complete procedure	14 045.00		+L		S
	TEMPOROMANDIBULAR JOINT PROCEDURES					
	For Items 9081, 9083 and 9092 the full fee may be charged per side					
9073	Bite plate for TMJ dysfunction	775.00		+L		B
9074	Diagnostic arthroscopy	2 121.00				S
9075	Condylectomy or coronoidectomy or both (extra-oral approach	5 329.00				S
9076	Arthrocentesis TMJ	1 265.00				S
9053	Coronoidectomy (intra-oral approach	2 663.00				S
9077	Intra-articular injection, per injection	319.00				S
9079	Trigger point injection, per injection	251.00				S
9081	Condyle neck osteotomy (Ward/ Kostecka	2 130.00				S
9083	Temporomandibular joint arthroplasty	5 329.00				S
9085	Reduction of temporomandibular joint dislocation without anaesthetic	427.00				S
9087	Reduction of temporomandibular joint dislocation, with anaesthetic	856.00				S
9089	Reduction of temporomandibular joint dislocation, with anaesthetic and immobilisation	2 130.00				S
9091	Reduction of temporomandibular joint dislocation requiring open reduction	5 329.00				S
9092	Total joint reconstruction with alloplastic material or bone (includes condylectomy and coronoidectomy)	14 221.00		+L		S

	SALIVARY GLANDS					
9093	Removal of salivary calculus	958.00				S
9095	Removal of sublingual salivary gland	2 559.00				S
9096	Removal of salivary gland (extra-oral)	3 793.00				S
	IMPLANTS					
	For items 9180 to 9192 the full fee may be charged, i.e. Note 2 of Rule 011 will not apply					
9180	Placement of sub-periosteal implant - Preparatory procedure/operation	2 990.00				S
9181	Placement of sub-periosteal implant prosthesis/ operation	2 990.00				S
9182	Placement of endosteal implant, per implant/	1 495.00		+L		S
9183	Placement of a single osseo-integrated implant per jaw	1 910.00				S
9184	Placement of a second osseo-integrated implant in the same jaw	1 431.00				S
9185	Placement of a third and subsequent osseo-integrated implant in the same jaw, per implant	956.00				S
9189	Cost of implants	Rule 013				
9190	Exposure of a single osseo-integrated implant and placement of a transmucosal element	704.00				S
9191	Exposure of a second osseo-integrated implant and placement of a transmucosal element in the same jaw	531.00				S
9192	Exposure of a third and subsequent osseo-integrated implant in the same jaw, per implant	366.00				S
8761	Masticatory mucosal autograft and subepithelial connective tissue autograft extending across not more than four teeth (isolated procedure	1 293.00		+L		A
8767	Bone regenerative/ repair procedure at a single site	1,650.00				A
	(Excluding cost of regenerative material - see code 8770)					
8769	Subsequent removal of membrane used for guided tissue regeneration procedure	777.00				A
	Codes 8761, 8767 and 8769 to be used only as part of implant surgery					
8770	Cost of bone regenerative/repair material	Rule 013				
	CLEFT LIP AND PALATE					
9220	Repair of cleft hard palate (unilateral)	7 843.00				S
9222	Repair of cleft hard palate (bilateral, one procedure)	9 964.00				S
9224	Repair of cleft hard palate (bilateral, in two procedures	14 837.00				S
9226	Repair of cleft soft palate (without muscle reconstruction)	6 573.00				S
9228	Repair of soft palatum (with muscle reconstruction	9 547.00				S
9230	Repair of submucosal cleft and/or bifid uvula (with muscle reconstruction)	7 107.00				S
9232	Velopharyngeal reconstruction (uncomplicated)	7 315.00				S
9234	Velopharyngeal reconstruction (complicated type)	7 817.00				S
9238	Functional repair of oro-nasal fistula (distant flaps - in a single procedure)	4 410.00				S
9240	Functional repair of oro-nasal fistula (distant flaps - in two procedures)	7 800.00				S
9246	SecoDBNry periosteal swivel flaps for bone induction	3 900.00				S
9248	Lipadhesion	3 462.00				S
9250	Unilateral cleft lip repair (without muscle reconstruction)	6 923.00				S
9252	Unilateral cleft lip repair (with muscle reconstruction)	9 396.00				S
9254	Bilateral cleft lip repair (without muscle reconstruction)	10 879.00				S
9256	Bilateral cleft lip repair (with muscle reconstruction)	16 813.00				S

• = New Code * = Revised Code

9258	Anterior nasal floor repair (between alveolus)	4 451.00				S
9260	Partial revision of secondary cleft lip deformity	4 451.00				S
9262	Total revision of secondary cleft lip deformity (with functional muscle reconstruction)	8 901.00				S
9264	Abbe-flap (in two stages)	16 813.00				S
9266	Columella reconstruction	9 396.00				S
9268	Partial reconstruction of nose due to cleft deformity	9 396.00				S
9270	Complete reconstruction of the nose due to cleft deformity	14 835.00	14,473.68			S
9272	Paranasal augmentation for nasal base deviation	4 451.00	4,342.11			S

ADDITIONS, DELETIONS AND REVISIONS			
Codes Kodes	Description		Notes
8132	Terminology revised		
8147	Code added		
8153	Terminology revised		
8180	Terminology revised		
8209	Terminology revised		
8213	Terminology revised		
8214	Terminology revised		
8529	Terminology revised		
8771	Code deleted		See Code 9009
8937	Terminology revised		
8953	Terminology revised		
8955	Terminology revised		
8962	Code added		
8963	Code added		
8964	Code added		
8978	Code deleted		
9066	Code added		

• = New Code * = Revised Code

GENERAL PRACTITIONER'S GUIDELINE TO THE CORRECT USE OF TREATMENT CODES

INTRODUCTION

The Dental Board respects the clinical freedom and judgement of every practitioner to institute whatever treatment he or she considers appropriate in given circumstances, provided it is based on a sound clinical diagnosis and the patient is given an informed choice regarding treatment options available.

In view of the increasing complexity of the Namibian Dental Board (DBN) treatment codes and the application thereof, and the misunderstanding which sometimes results, and in order to eradicate the disturbing trend of wrongful, or fraudulent application of treatment codes, the DBN has drawn up these *guide*lines. Reference to these *guidelines* will promote the correct use of certain items of the DBN fee schedule, which may be either misunderstood or misinterpreted by practitioners. In this way the highest standards of ethical practice will be maintained.

These *guidelines* will be updated periodically and for this reason the Dental Board will value comments on any aspect of this publication.

Good record keeping assists in dento-legal matters.These Guidelines were prepared by **Dr Harold Levenstein** for the **General Practice Committee** of the SADA. They have been modified for the Namibian Dental Board by **Dr Martin Wucher.**

CODE

8099 Laboratory Fee

Laboratory fees are chargeable on presentation of the invoice. Where a patient fails to return for the completion of the treatment the laboratory fee should be charged.

The DBN accepts that the *patient* can be required to pay an *initial amount to* cover laboratory costs.

8101 Full mouth examination, charting and treatment planning

No further examination fee shall be chargeable until the treatment plan resulting from the consultation is completed with the exception of Items **8102.**

The full mouth examination, charting and treatment planning **must** be recorded on a treatment card, keeping accurate and legible records. This may be important in dento-legal cases.

Code 8101

May include the issuing of a prescription. If a dentist who is registered as a dispensing dentist does dispense medication then it is recommended that medicine used in treatment should have a mark-up of not more than 50% of the cost price and must not exceed the retail ethical price list, which is obtainable from Pharmaceutical Publishers, PO Box 27118, Sunnyside 0132. The medicine account must be separated from the services account. Dentists who are registered to dispense must strictly observe the applicable rules published by the Pharmacy Board.

Note: When a patient is consulted for an emergency or a specific problem and did not come in for a full mouth examination and charting, then **Code 8101 cannot be charged.** Under these circumstances **Code 8104** – Consultation for a specific problem - must be charged.

8102 Comprehensive Consultation

The guidelines on which this code item is based are set out in the National Schedule of Fees.

These guidelines specify the complete documentation of all the relevant medical and

dental data in respect of the particular patient with regard to the procedures as listed under Code 8102. The diagnosis and the recommended treatment plans, as well as alternatives, are based on this data. Furthermore, all such data must be recorded in an acceptable and transmissible form and must be presented to the patient in writing.

8104 Consultation for a specific problem not requiring full mouth examination and treatment planning.
Cannot be charged when 8101 has been charged. Can only be charged for a specific problem which does not form part of an original treatment plan and may not be used in conjunction with a regular appointment. Code 8104 may include the issuing of a prescription. If a dentist who is registered as a dispensing dentist does dispense medication then it is recommended that medicine used in treatment should have a mark-up of not more than 50% of the cost price and must not exceed the retail ethical price list, which is obtainable from Pharmaceutical Publishers, PO Box 27118, Sunnyside 0132. The medicine account must be separated from the services account. Dentists who are registered to dispense must strictly observe the applicable rules published by the Pharmacy Board.

8107, 8108, 8113, 8114, 8115:
Radiographs
It is the duty of every dentist who takes radiographs to ensure full compliance with the Regulations concerning safe radiological practice for the protection of the patient. Failure to do so may lead to disciplinary proceedings.

The frequency with which a patient is X-rayed and the number of radiographs taken is left to the clinical experience and discretion of the practitioner as well as his or her integrity. **If a patient refuses to have a radiograph, this fact must be recorded on the record card.**

All radiographs charged must be of good quality or they must *be re-done at no charge.*

As a general rule:-

- Full mouth radiographs are taken once for clinical record purposes - the only exception is a follow-up of the patient, e.g. after periodontal surgery.
- Panoramic radiographs are only taken *once* – except in cases where a follow-up is essential, e.g. surgery, trauma, orthodontic treatment and re-evaluation of wisdom teeth.
- Radiographs are required pre-operatively for endodontic treatment, periodontal treatment, the surgical extraction of teeth or roots, crown or bridgework.
- Major orthodontic treatment should not be undertaken without cephalometric and panoramic radiographs.

No unerupted tooth should be extracted without pre-op radiographs which clearly show the whole tooth and its relationship to important anatomical landmarks.

A report must be written down on the treatment card following the taking of any radiographs and the sites of the radiographs taken must also be recorded. **The dentist who takes the radiographs owns them.** Radiographs are an integral part of the patient's records and should be retained for a minimum of five years. If a patient who has paid for his/her radiographs requests that they be given to him/her either for a second opinion or because he/she has changed dentists, then the dentist who took the radiographs may send the radiographs direct to the new dentist for viewing only. Duplicates of the films can be provided to the patient at a fee.

Radiographs can provide invaluable dento-legal evidence and their loss may prejudice a practitioner's defence.

8117 Study models - unmounted and

8119 Study models mounted on adjustable articulator

Study models are plaster or stone models of the teeth and adjoining tissues of the upper and lower jaws.

Codes 8117 and 8119 include both upper and lower models. *Study models are not working models; they are used for treatment planning and should be retained for record purposes.* Study models can not be used for the *construction* of crowns or dentures. An impression of the opposing arch for the bite registration is *not a* study model. A model used for the construction of a special tray cannot be classed as a study model.

8129 Emergency visit – after regularly scheduled hours
Applicable to instances where a dental practitioner is called out from his/her home to his/her rooms after normal working hours, or a hospital, to render emergency treatment.

Note: Code 8129 is not applicable when working late after normal working hours on routine dental treatment, nor if a practice routinely operates on a Saturday, Sunday or Public Holiday.

8131 Emergency treatment where no other tariff item is applicable
Code 8131 cannot be used in addition to any other item if it involves treatment on the same tooth. It is also not applicable where a patient has made a prior appointment as part of an existing, unfinished, treatment plan, for routine procedures.

8137 Temporary crown as an emergency procedure
An emergency crown is usually constructed in the treatment of a *fractured tooth* or where the patient has lost a previously fitted permanent crown. An emergency crown is a preformed or manufactured crown, usually made of metal or resin, which is fitted over a damaged tooth as an immediate protective device or for aesthetic purposes.
This procedure may not be applied to elective crown and bridgework and is especially not applicable to temporary crowns placed during routine crown and bridge preparations.

An Acrylic Jacket Crown (8405) is a **permanent** and not a temporary crown.

Code 8529 in the Prosthodontic Schedule refers to a provisional crown placed, for example before or after periodontal surgery, during the healing period before the final crown preparation and impressions are taken or as a diagnostic crown.

8141 Electronic Analgesia
Electronic Analgesia (8141) can only be charged when it is the sole form of analgesia administered and not when it is used to make Local Anaesthesia (Code 8145) more comfortable for the patient.

8145 Local anaesthesia per visit
This fee is for the administration of local anaesthesia by injection per visit, irrespective of the number of injections given/ampoules used at that visit.

The use of the "Wand" is a technique and not a procedure and Code 8145 is the correct Code to be used.

8151 Oral Hygiene Instruction
Patients should be informed that a fee will be charged for oral hygiene instruction. A standard oral hygiene instruction procedure *usually* includes the following:-

(i) Plaque control information, e.g. instruction pamphlets or leaflets;
(ii) Dietary instructions;
(iii) Explanation and demonstration of plaque control (brushing and flossing);
(iv) Self-practice session in the mouth under professional supervision;
(v) Use of special aids such as disclosing agents;
(vi) Scoring of plaque levels (plaque index);

Oral hygiene instructions on a child under 9 years of age should take place in the presence of a parent.

8153 Follow-up visit for re-evaluation of oral hygiene
This would encompass evaluating and monitoring the steps in 8151.
Any follow-up visits for re-evaluation of oral hygiene instructions, in the same course of treatment, may only be charged under **Code 8153.**

8159 Scaling and polishing
The presence of supra- or subgingival calculus will determine whether this procedure is justifiable in a child under 1 0 years of age.

8161 Topical application of fluoride
Fluoride has a beneficial effect throughout a person's lifetime.
The use of a fluoridated paste during polishing is not a topical fluoride application.
Code 8161 can only be charged when a tray is used to apply the fluoride.

8163 Fissure sealant, per tooth
A general rule is that caries-free teeth that have been in the mouth for longer than 4 to 6 years or those with shallow wide grooves, need not be sealed.

8167 Treatment of hypersensitive dentine, per visit
This is charged once only irrespective of the number of teeth treated per visit. This Code may not be used together with Code 8161.

8169 Bite Plate for TMJ dysfunction or occlusal guard
This refers to a removable dental appliance which is designed to minimise the effects of bruxism (clenching and grinding) and other occlusal factors. This Code is not applicable to mouth protectors (Code 8171).

8170 Minor occlusal adjustment
This may also be known as equilibration; reshaping occlusal surfaces of teeth or restorations by grinding to create harmonious contact relationships between the upper and lower teeth.

Not applicable to adjustment of a denture or a restoration fitted or placed as part of a current treatment plan.

8182 Root Planing with or without periodontal curettage per quadrant. A quadrant consists of 7 or 8 teeth.

8184 Root Planing with or without periodontal curettage per sextant
A sextant usually comprises 6 teeth or between 4-6 teeth.

If a periodontally compromised patient is to undergo periodontal treatment in the form of *Root Planing* - Codes 8182 and 8184 - it is essential that *certain diagnostic procedures and preliminary treatment* ***must first*** *be carried out*, namely:-

(1) X-rays are required to evaluate bone level, infra-bony pockets and calculus.
(2) Periodontal screening (Code 8176) which should include the recording of at least:-
  (a) Complete pocket charting
  (b) Plaque index
  (c) Bleeding index
(3) A Scaling and Polishing *at a previous appointment* **prior** to root planing.
(4) Oral hygiene instructions at a previous appointment and the patient must be recalled to evaluate the instructions.

Once the *periodontally compromised patient* has undergone the above treatment, ideally, the patient should be recalled after approximately one month and a periodontal screening should be carried out again to evaluate the success of the treatment.

When new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered. The successful long-term control of periodontal disease depends upon active maintenance care through supportive periodontal treatment.

Active periodontal therapy may consist of surgical or non-surgical services or both.

Periodic maintenance treatment following active therapy is not synonymous with a prophylaxis.

8185 Gingivectomy-gingivoplasty per quadrant and
8186 Gingivectomy - gingivoplasty per sextant
Gingivectomy is a very old procedure and is no longer a mainstream periodontal procedure.

Note: Scaling and polishing (Code 8159) is usually carried out prior to Code 8185 or Code 8186.

Oral Surgery (See Rule 011)
When a professional assistant is used his/her name must appear on the account rendered to the patient and the patient must be informed, beforehand, that an assistant will be used.

Implants
DBN does not approve of the re-use of any implant components because of the hazards to the patient.

When an implant fixture is placed for osseointegration, the following is charged:

Surgery 8194, 8195
Components 8197

When the fixture is exposed after osseointegration, the following fee is charged:

Surgery 8198
Components 8197
(Usually a transmucosal healing abutment)

After the second stage surgery and an appropriate healing period, the abutment components are attached to the fixture, an impression is taken, and the following is charged:

Components 8197
(Usually the abutment, Impression Copings, Healing Caps, Abutment Replicas)

The laboratory constructs, to your prescription, a crown made to fit the abutment replica. In doing so the laboratory will also charge, on the laboratory invoice, for components that might have been used, e.g. abutment replicas, gold cylinders and gold screws

When the laboratory work is secured to the abutment for the patient, to complete the restoration, the following is charged:

Osseo-integrated Abutment Restoration 8193 Laboratory Fee 8099
Note: No fee is levied apart from 8193 and 8099. One can not charge for the particular restoration actually placed, as Code 8193 already includes this fee. Code 8193 is charged and not 8409, 8411 etc.

Where a pre-angulated abutment is placed (to correct alignment of the FIXTURES) this is then charged as 8600 (Implant components).

When a cast coping is custom made in a laboratory to correct alignment of fixtures it is then permissible to charge for 8396 (Cast Coping) or 8587 (Cast Coping: Prosthodontists Schedule) in addition to 8193 and 8099 for the restoration of an Osseointegrated Abutment.

If a bridge is constructed on one or more implant fixtures the pontics are charged for as in conventional crown and bridgework, e.g.

- Sanitary pontic 8420
- Posterior pontic 8422
- Anterior pontic 8424 and the
- Bridge abutments per abutment (8193).

Removable Implant Prostheses

First Surgical Stage

- Surgical placement of implants 8194-8196
- Components 8197

Second Surgical Stage

- Surgery and placement of transmucosal element (usually transmucosal abutment) 8198-8199
- Cost of Transmucosal element 8197

In some cases tissue conditioning and soft self-cure interim re-line to denture (8265) may be necessary after the first and second surgical stage.

Prosthodontic Procedures

Superstructure, i.e. denture, 8231 or 8232
The metal superstructure of the implant is covered by the charge for the abutment 8193+L (8099).

Laboratory costs (8099) will be incurred at all stages. Components used at all stages will be charged as 8197. Periodic maintenance of implants is charged as 8590 by specialist prosthodontists and as two-thirds of 8590 by general practitioner dentists.

8209 Surgical removal of a tooth, i.e., raising of a mucoperiosteal flap, removal of bone and suturing

Note: If a tooth fractures during an extraction, leaving the roots behind then Code 8209 is applicable and not Codes 8213 and 8214.

Unerupted or impacted teeth

If an unerupted and impacted canine or premolar were to be removed **in addition** to four unerupted and impacted wisdom teeth then the fees should be rendered as follows:-

8210	First tooth
8211	Second tooth
8212x 3	Third and subsequent teeth, per tooth

8213 Surgical removal of residual roots of first tooth and
8214 Surgical removal of residual roots of each subsequent tooth. (See Rule 011)

Residual roots are roots in the absence of a crown prior to surgical intervention. This procedure requires the raising of a flap, removal of bone and suturing.

Note: Codes **8213** and **8214** refer to roots left behind, buried or retained roots lying under the mucosa and detected by radiographs, which are essential for this procedure.

The residual roots would have been there for some time, and should not have resulted at the time of an extraction of a tooth, i.e., this fee cannot be applied when the dentist, at the same appointment, has broken a tooth.

8220 Use of suture provided by practitioner

This fee refers to one pack of suture material.

8221 Local treatment of post-extraction haemorrhage

This Code is charged for a subsequent visit following an extraction. It may not be charged during the visit for the extraction of that particular tooth.

8273 Additional fee where one or more impressions are required for Codes 8269, 8270, 8271 and 8846
This code can be charged *only once* irrespective whether upper and/or lower impressions are taken. It cannot be used for the taking of impressions for any other procedure.

8301 Direct Pulp Capping
Procedures in which the *exposed pulp* is covered with a dressing or cement that protects the pulp and promotes healing and repair.
Only applicable for frank pulp exposure with pinpoint haemorrhage. *Linings in deep cavities are not classed as a direct or indirect pulp cap.*

8303 Indirect pulp capping where permanent filling is not completed at same visit
A dressing of Calcium Hydroxide is placed over a thin partition of remaining carious dentine which, if removed, might expose the dental pulp. This dressing protects the pulp from additional injury and permits healing and repair via formation of secondary dentine. The temporary restoration of Zinc Oxide - Eugenol covering the Calcium Hydroxide, is left for 6 weeks. According to the literature (see Massler) a *minimum* period of six weeks should be allowed. When the cavity is examined, all infected dentine must be removed and, if there is any doubt about this, a further period of six weeks should be allowed. Under these conditions, 8303 may again be charged for the *same tooth.*

8305 Apexification of root canal, per visit
Apexification is the induction of apical closure and the continued development of an immature tooth in which the pulp is no longer vital. During apexification, as an isolated procedure it could take from months to years for apical closure to occur. The patient is recalled approximately every 4 months for assessment and change of the Calcium Hydroxide dressing.

Apexogenesis is physiological root end development and formation. After pulp exposure of an incompletely formed tooth in which the pulp is apparently vital, a pulpotomy or pulp-capping procedure may allow apical closure with deposition of dentine and cementum. The main difference between Apexification and Apexogenesis is that in the former the tooth is non-vital and in the latter the tooth is *vital.* In both Apexification and Apexogenesis the teeth are immature with incompletely formed apices.

Note: The Code and fee for both Apexification and Apexogenesis is the same.

8307 Amputation of pulp (pulpotomy)
A pulpotomy cannot be charged together with any other endodontic procedure, such as a preparatory visit or obturation, on the same tooth.

8328 to 8330 & 8332 to 8340: Endodontics

Codes for endodontic procedures for general practitioners are applicable to primary **and** permanent teeth.

Radiographs are essential in endodontic treatment. The use of electronic apex locators should not preclude the taking of pre- and post-operative radiographs.

Note: Codes 8336, 8337, 8339 and 8340 refer to root canal therapy on *molars only* and thus these codes may not be used on pre-molars.

8334 Re-preparation of previously obturated canal, per canal (in the re-treatment of a tooth)

Endodontic re-treatment would include the removal of old gutta percha, silver points, cements and the cleaning and shaping of all the root canals.

In a re-treatment case the practitioner would charge Code 8334 per canal at the first visit.

If by chance in a molar with 3-4 canals, it was not possible to complete the re-preparation of all the canals at the first visit, then the remaining canals could be charged using Code 8334 at the second visit, i.e. each canal is charged only once.

If the tooth required any further cleaning and shaping, then the practitioner may charge Code 8333 **in a multi-canal tooth** where appliable, at any subsequent visits up to a maximum of four visits **per tooth**.

In re-treatment of a single canal, Code 8334 would be charged at the first visit and Code 8332, where applicable, at any subsequent visits up to a maximum of four visits **per tooth**.

Codes 8332 and 8333 may not be charged together with Code 8334 at the same visit **on the same tooth**.

If a previously undetected root canal was found during the re-treatment of a tooth, Code 8334 can only be charged for the re-preparation of each previously obturated canal and not for the preparation of the undetected (and therefore not previously obturated) canal. If, however, the preparation and the obturation of the undetected canal were completed at the same single visit, then the fee for this undetected canal would be charged under Code 8338 or 8339.

When the obturation of the canal/s is carried out at a subsequent visit, then Codes 8335, 8328, 8336 and 8337 would be used where applicable.

8371 - Ceramic/Resin bonded inlays
8374 - and veneers and

8560 Cost of Ceramic Block
For computer generated inlays it is recommended that laboratory technicians Code 9512 with their Rule 002 be charged as 8099 on the practitioner's account. The cost of material is charged as Code 8560 in accordance with Rule 013. An invoice should be attached indicating that computer technology, e.g. CADCAM or CEREC was used and that manufacture did not take place in the dentist's laboratory.

Note: If computer generated inlays are manufactured at the chairside, no fee is chargeable for the use of an articulator or models.

8354 Four-or-more surface acid etch restoration
Large acid etch restorations carried out on deciduous teeth, particularly under a full course of dental treatment under general anaesthetic, can not be charged out as **8405 -** Acrylic Jacket Crowns.

8376 Prefabricated post and **core**
NB: This item is inclusive of pins.
Code 8376 has the same quantum of fee irrespective of the number of posts used. Obviously, this treatment is only possible on a root-treated tooth.

8396 Cast Coping

The following **description of Copings** is derived from *"Precision attachments in Prosthodontics: Overdentures and Telescopic Prostheses"*, Volume 2, by Harold W Prieskel. Two types are described and both are of cast metal.

1. **Thimble Coping:** May utilise pins for additional retention. Generally used to parallel cavity preparations for bridges and splints. May be similarly used to parallel abutments where implant fixtures are not parallel.

2. **Dome-shaped Coping (with post)** for endodontically treated overdenture abutment teeth.

8398 Core build-up irrespective of number of pins used
If a core build-up in amalgam, glass-ionomer or resin is carried out without pin retention, then the respective fee for the plastic restoration only should be charged such as Codes 8344, 8354 or 8370. Code 8398 is then not applicable.

8405 Acrylic Jacket Crown
The crown should be an indirect heat cured crown constructed in the laboratory. This fee is not applicable to stock plastic crowns or to four-surface Acid Etch Restorations (see 8354).

Note: Specialists' Fees Rule 009 - General dental practitioners may charge two-thirds of the fees of specialists, *only* ***for treatment that is not listed in the*** *fees for dentists* in ***General Practice and Modifier 8004 must be shown against any such item.***

8409 - Porcelain jacket crown
8607 - Codes 8409 and 8607 (Prosthodontists Schedule) include any crowns which do not have a metal base, e.g. Targis Vectris, Inceram etc..

8411 Porcelain Veneered Crown
8609 Codes 8411 and 8609 (Prosthodontists Schedule) apply to any **metal-based** porcelain veneered crowns.

8529 Provisional crown, which is not placed during routine crown preparation
A provisional crown does not refer to an interim crown placed after crown preparation and impression taking and pending delivery of the permanent crown.

8551 Major occlusal adjustment
Major occlusal adjustment may require several appointments of varying length, and sedation may be necessary to attain adequate relaxation of the musculature. Study models mounted on an adjustable condyle articulator (e.g., Hanau) must be utilised for analysis of occlusal disharmony.

8560 Cost of ceramic block
Code 8560 is for the cost of the ceramic block only and does not include the cost of any materials, models, articulators etc.

8721 Occlusal adjustment per visit
Codes 8553 and 8721 are not applicable to adjustments of a denture or of a restoration fitted or placed as part of a current treatment plan.

8592 Osseo-integrated abutment, per abutment (see corresponding codes 8193 to 8197 on pages 8 and 9)
It is not permissible to charge an additional amount e.g. Code 8411 - Porcelain Jacket Crown, as well as Code 8592. The plastic (composite) acid etch restoration used to cover the screw of the implant can be charged as an additional one surface acid etch restoration Code 8351 or 8367. If fixed bridgework is performed, the crown over the implant is considered the abutment.

8637 Hemisection of a tooth or resection of root and
8765 Hemisection of a tooth/resection of a root apicectomy including retrograde filling where necessary, but excluding endodontics (as an isolated procedure)
Hemisection includes separation of a multirooted tooth into separate sections containing the root and overlying portion of the crown. It may also include the surgical removal of one or more of those sections.

8756 Flap operation with bone removal to increase clinical length of a single tooth (as an isolated procedure).
This is a surgical procedure exposing more tooth for restorative purposes by apically positioning the gingival margin and removing supporting bone.

Note: Electro-surgery at the time of crown preparation and impression taking with cord retraction, cannot be charged as a crown lengthening procedure.

8763 Wedge resection (as an isolated procedure)
Wedge resection is a periodontal procedure to reduce the bulky retromolar tissue forming the distal wall of a pocket. This could be distal to either a wisdom tooth or to a second molar upper or lower.

Note: The use of electro-surgery or cautery on its own does not constitute a fee for this procedure.

ORTHODONTIC FEES: GENERAL DENTAL PRACTITIONERS

There is often confusion with regard to the selection of Codes and rendering of accounts for orthodontic treatment by general practitioners. Attention is drawn to the following:-

1. Where an account refers to **orthodontic services**, a statement containing the following information shall accompany the first account to the patient:-

(a) the code number of the envisaged treatment:
(b) a plan of treatment indicating the following:-
  (i) the total tariff that would be charged by the practitioner for the treatment;
  (ii) the duration of treatment;
  (iii) the initial primary tariff payable by the member;
  (iv) the monthly tariff to be paid by the member.

2. As there are no specific codes for orthodontic treatment in the General Practitioners' section of the National Schedule of Fees or in the Scale of Benefits, the General Practitioner must refer to the Specialist Orthodontists Schedule. The codes for the treatment must be quoted together with the Modifier **8004** (refer to Rules **009** and **011**). This denotes that a General Practitioner is delivering the treatment and the fee is calculated as up to two-thirds of the appropriate specialist fee. Where "L" is denoted this can be added on to the two-thirds fee. If "L" is not denoted then this is incorporated in the appropriate two-thirds fee and *cannot be added to the account.*

3. The fee for Corrective Therapy (i.e. Codes **8861** to **8888)** is *a fully inclusive fee and no additional fees* may be charged for additional visits (Code **8803**) until the treatment is completed.

4. **Removable Appliance Therapy (8862 & 8863)**
Removable appliance therapy indicates that the patient is able to remove and replace the appliance *at will.*

Codes 8862-8863 are usually reserved for simple minor tooth movement and treatment would not normally extend over a longer period of time. **No** additional charges can be made for adjustment.

5. **Functional Appliances**

Functional appliance therapy is classified under code 8858 and is only very rarely not followed by full fixed appliance therapy. Functional appliances are usually used as a first step in order to simplify the second stage of full fixed appliance treatment.

The fee charged for the functional appliance is deducted from the full fixed appliance fee and the remainder then becomes the fee charged for the second stage of the full fixed appliance therapy.

6. Fixed Appliance Therapy

Fixed appliance therapy indicates that the appliance is fixed and cannot be removed by the patient at will.
All malocclusion codes listed under Fixed Appliance Therapy, i.e. 8865-8888, will invariably require, for the correction of the respective malocclusion, fixed appliances as the major component of appliance therapy *No laboratory fees* are charged for Codes 8861 and 8865 to 8888.

NB: *These codes cannot be used for removable appliance therapy.*
Some of the features that merit consideration and require full fixed appliances for their correction are:

(a) Class II and Class III skeletal relationships.
(b) Vertical discrepancies such as excessive anterior facial height, or reduced anterior facial height.
(c) Profile changes such as excessive protrusion and retrusion of the lips.
(d) Dental malalignment such as overjet and overbite, correction, individual rotation and angulation, and the correct relationship of the maxillary and mandibular dental arches to each other.
(e) The stability of the final result.

To further assist the General Practitioner in the interpretation of the Orthodontic Schedule, please note the following:-

Payment

For fixed appliance therapy the fee payment arrangements are usually as follows:-

(a) The practitioner decides upon a fee and the appropriate treatment code.

(b) An initial fee is deducted from the total and the balance is reduced on a monthly basis over the estimated treatment time.