OMG Coding Companion 2024

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Table of Contents

1. Introduction

The objective of this coding guide is to provide an extract of the top codes being used by Ophthalmologists and does not include all codes. The items used in this guide are from the Medical Doctors' Coding Manual (MDCM) published by SAMA in 2022/2023, which are those recognised by OMG, as these have been peer-reviewed by the profession. In cases where disputes arise, OMG and SAMA are available to review and resolve the issues which have been raised.

In 2022, the Council for Medical Schemes issued Circular 66, in which it declared that it will use the 2006 National Health Reference Price List (NHRPL) for adjudication of any disputes at the level of the Council. The South African Private Practitioners Forum has vehemently objected to this approach on the basis that the 2006 list is now greatly outdated. At the time of writing of this guideline, however, this dispute remains unresolved, and schemes are using circular 66 as a reference to their coding decisions.

It is not always possible to reflect all the work components of a procedure in its descriptor. Coded procedures do however represent international standards of what a particular procedure exactly encompasses.

The clinical verification edits in this publication indicate which code(s) may not be used in conjunction with the major procedure code in left hand column. Additional information, and motivation would be needed if there was any justification for one or more of these indicated codes.

Please note that SAPPF has appointed a coding specialist whom may be contacted for coding assistance.
This guide is a work in progress and the OMG Board of Directors will appreciate your feedback, comments and criticisms on how to improve this guide!

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1. Coding Scheme Overview

There are three main coding schemes used in South Africa:

- ICD-10
- CCSA (CPT for South Africa)
- MDCM

Accurate coding using these three schemes is encouraged, as well as the correct combination of procedure codes in relation to ICD-10 codes. Combining the correct codes ensures that funders can determine that levels of care are appropriate and should reduce queries and delayed payments.

1.1. ICD-10: The South African Diagnostic Coding Scheme

ICD-10 = International Statistical Classification of Diseases and Related Health Problems, 10th Edition

The WHO (World Health Organisation) is the custodian of ICD-10 coding.

It is an alpha-numeric coding structure. The code could be valid up to the 3rd, 4th or 5th character.

	ICD-10 Code						Description
Valid up to the 3rd character	H55	1st	2nd	3rd	4th	5th	Nystagmus and other eye movements
		H	**5**	**5**			
Valid up to the 4th character	H43.2	1st	2nd	3rd	4th	5th	Crystalline deposits in vitreous body
		H	**4**	**3**	**2**		
Valid up to the 5th character	S02.3**0**	1st	2nd	3rd	4th	5th	Fracture of orbital floor, **closed**
		S	**0**	**2**	**3**	**0**	
	S02.30 must always be accompanied by the external cause code describing the circumstances of injury sustained (e.g. motor accident), place of occurrence and activity code from Chapters: V, W, X & Y.						

Please take note that a "full stop" (.) is not seen as a "character".

Fact:

It is also true that the ophthalmology section of ICD-10 has the most dagger (+) and asterisks (*) combinations available. In some instances, only the combination of ICD-10 codes will qualify in terms of PMBs.

1.2. CCSA: The South African Procedural Coding Scheme

CCSA 2022 = Complete Current Procedural Terminology for South Africa 2022. In America it is known as CPT (Physicians' Current Procedural Terminology). It is licenced to SAMA (South African Medical Association) by the AMA (American Medical Association). CCSA is a five-digit numerical coding structure e.g., **"67110 – Repair of retinal detachment; by injection of air or other gas (e.g. pneumatic retinopexy)"**

1.3. MDCM: The South African Procedural Billing Coding Scheme

MDCM = Medical Doctors' Coding Manual

This coding structure is also known as "Tariff" or "RPL". It is managed, licenced and distributed by SAMA (the South African Medical Association). It has a four-digit numerical code structure e.g. **"3096 – Adding of air or gas in vitreous as a post-operative procedure or pneumo-retinopexy "**

2. History of Billing Coding in South Africa

The billing coding history in South Africa, can be divided into 2 chapters. The period before 2004 and the period after 2004.

2.1. The period before 2004

The Medical Profession determined the codes and the descriptors of the codes. The Professional Associations set the private fees. The Health Professions Council of South Africa (HPCSA) calculated overcharging by using the private billing rate (SAMA) plus 20%. Annual negotiations with Board of Healthcare Funders (BHF) and SAMA resulted in the maintenance of the coding structure. SAMA and BHF set separate price adjustments for benefits and fees.

2.2. The period after 2004

The Competition Commission launched an investigation into the coding benefit calculations and fees. The process was declared illegal and parties involved were fined. The Council for Medical Schemes were responsible for the publication of the National Reference Price List (NHRPL). Negotiations between CMS, SAMA and BHF resulted in the NHRPL model. During 2005 the first NHRPL were published by CMS. The costing was calculated using 2004 NHRPL + CPIX. HPCSA created an Ethical Tariff based on the SAMA tariff + CPIX. [SAMA tariff = (NHRPL x 3) + CPIX]. Mid-2006-2007 the National Department of Health (NdoH) assumed responsibility for the further development of the NHRPL. The NHRPL was renamed to Reference Price List (RPL). The CMS model are still used, but the consultative process came to a halt. RPL was published in 2009 using 2008 NHRPL + CPIX.

The South African Private Practitioners Forum (SAPPF), twenty-two (22) disciplines, HASA and the Emergency services challenge the legality of the 2009 RPL. The RPL 2009 was declared illegal and invalid in July 2010. No code maintenance has been possible since the NdoH intervention. New technology and improved procedures cannot be billed for, since no reimbursement code exists in the South African Healthcare sector.

The current coding structure is running out of numbers. South Africa is in need of a comprehensive coding structure for both public as well as private sectors, describing medical, surgical and diagnostic services rendered by all healthcare professionals (medical and allied).

2.3. The Competition Commission Health Market Inquiry (2014 to 2019)

The private sector Health Market Inquiry which was undertaken by the South African Competition Commission between 2014 and 2019, recognised the many issues inherent in clinical coding in South Africa and made several recommendations about how this could be addressed.

3. Coding Structure

3.1. Important principles to apply in billing

- The basic building blocks of a bill are codes viz. ICD-10 Diagnosis Codes, Procedure Codes and Modifiers.
- Bill the most comprehensive procedure to report the service provided.
- When multiple procedures are performed and a code describes all the components of the service, that code must be used instead of multiple component codes.
- Be cognisant of what is **included and excluded** in each code.
- Commentaries in the coding guides may indicate scenarios where a code may be applied.
- If bilateral procedures are performed indicate e.g., Left eye and Right eye.
- If a code that accurately describes the procedure performed cannot be found, Rule C may be invoked, viz. Comparable services (see Rule C).

Contact Healthman for coding assistance in this regard as the utilisation of Rule C (item code 6999) may ultimately indicate the need for the introduction of a new code.

- Coding is paramount, from which units (RVU) flow, RCF (rand conversion factor) applied, and rand value generated.
- If the values are deemed too low, Rule J may be invoked. (see Rule J and modifier 0014). *The use of this rule is not intended merely to increase the medical scheme benefits* and will require an operative report describing the complex nature of the procedure and extended theatre time.
- The Scheme may then apply their benefit rules to decide what percentage will be paid out to the providers.
- Correct codification is the most important.

3.2. General Rules governing the billing coding structure

A list of the most commonly utilised rules pertaining to the billing coding structure is briefly discussed. Surgical operative codes represent the work component of the operation itself and the normal uncomplicated postoperative care in-hospital or out of hospital for **four** weeks.

❖ **It is of utmost importance that practitioners and administrators read and understand how to use all the Rules in the latest SAMA MDCM (full guide).**

Rule A – A consultation/visit refers to face to face interaction

(a) **A consultation/visit** refers to a clinical situation where a medical doctor personally (excludes the time spend doing special investigations which receive additional remuneration):

- obtains a patient's medical history
- performs an appropriate clinical examination
- administers treatment (if indicated)
- prescribes or assists with advice.

These services must be face-to-face with the patient and excludes time spent doing special investigations which receive additional remuneration.

(b) Hospital visit:

- Where a procedure or operation was done, hospital visits are regarded as part of the normal after-care and may not be coded unless otherwise indicated with a unique ICD-10 code.
- Where **no** procedure or operation was carried out, a hospital visit according to the appropriate hospital or inpatient follow-up visit may be coded.

Rule B – Normal hours and after hours

If a non-emergency elective visit/consultation falls outside of the normal practice hours, and the patient requested the time for their own convenience, please refer to code 0148. Kindly note that the member/patient will be responsible for payment hereof.

Bona fide emergency consultation/visit (21h00 – 06:00 daily), refer to **code 0149**. Kindly note that the member/patient will be responsible for payment hereof if the services fall outside of the medical scheme benefits.

To avoid unnecessary retrospective reversals, take note of the following important note:
Most of the schemes / administrators apply the RPL 2006 code descriptions which means the original SAMA definition of *office hours,* i.e. 08:00 to 17:00 from Monday to Friday and 08:00 to 13:00 on Saturday. Therefore, services rendered outside of these hours are defined as being after hours and some have published guidelines for the consultation add-on codes as listed in the table below.

Rule C – Comparable Service (code 6999)

- As there is no medical practitioner code for new technology or service, Rule C will be based on the corresponding **CPT code, the CPT units are multiplied by 10** (in line with the 10:1 SAMA: CPT).
- Where a new SAMA code has been introduced but has not yet been accepted by the schemes, it may also be applied.
- The procedure is claimed under RPL **code 6999** (Unlisted procedure/service) and in the description field, please **describe the procedure and if the description of the CPT code is available it must be used as the description**. The relevant ICD-10 code should also accompany the claim.
- This will ultimately mean that it should be negotiated with the related scheme.

Rule C: *A service may be rendered that is not listed in this edition of the coding structure.*
The fee that may be charged for the rendering of a service not listed in this coding structure shall be based on the units of a comparable service. For these procedure(s)/service(s), item 6999: Unlisted procedure or service code, should be used. When item 6999 is used to indicate that an unlisted service was rendered, the use of the item must be supported by a motivation. This motivation must include:
(1) An adequate definition or description of the nature of the procedure/service;
(2) Final diagnosis supported by the appropriate ICD-10 code(s);

An example of the clinician's choice of a comparable code:

- Often new technology is reported under existing codes without consultation.
- A code has been introduced into the 2016 SAMA MDCM and a funder has not yet accepted it.

Bill as	**Description**

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6999	Rule C: 3038	Sensorimotor examination: With multiple measurements of ocular deviation; one or both eyes (e.g. restrictive or paretic muscle with diplopia) with interpretation and report, for children 7 years and younger

Contact Healthman for coding assistance in this regard as the utilisation of Rule C (item code 6999) may ultimately indicate the need for the introduction of a new code.

Rule D – Cancellation of appointment and no-shows

In cases where a patient did not show up for an appointment or did not take timely steps to cancel an appointment, Rule D may be applied to the relevant consultation item. Should the practitioner apply Rule D, all of the following must be adhered to:

(1) Timely cancellation of a general practitioner appointment must be two hours and in case of a specialist **one** calendar day prior to the appointment.

(2) The practitioner must be able to provide evidence of failure to find an alternative patient between the time of receiving the cancellation notice and the time of cancelled appointment.

(3) **The practitioner must be able to provide sufficient proof that the patient was informed at the time of booking about the cancellation of appointments policy.**

(4) The practitioner shall first establish the reasons for the patient's failure to cancel or honour the appointment (e.g., death and hospitalisation are excluded). Each case shall be considered on merit and, if circumstances warrant, the patient will not be held liable.

- **Medical schemes do not pay for this service.**

Rule G – Post-operative care

Unless otherwise stated, the fee/units of an operation or procedure shall include normal after-care for a period not exceeding **four (4)** weeks after the procedure has been performed. Normal after-care refers to an uncomplicated post-operative period not requiring any further incisions.

Treatment of the complication or exacerbation of an underlying co-morbidity that requires care other than normal after-care for the particular operation, will qualify for a follow-up visit or consultation item. Treatment of conditions such as (but not limited to) post-operative pneumonia, pyrexia, wound complications, prolonged ileus (>5 days) and DVT **is not considered** as part of normal after-care and should be reported by **means of the (unique) appropriate ICD-10 code.** Should the patient develop a post-operative complication, this should be reflected on the account from the day on which the complication occurred.

- Rule G will not apply to the treatment of conditions such as postoperative pneumonia, pyrexia, wound complications, prolonged ileus (>5 days) and DVT, etc.
- Rule G does not apply when purely diagnostic procedures, during which no therapeutic procedures were performed are done.
- Care of the condition for which the diagnostic procedure was performed, or other concomitant condition(s) not included, may be listed separately.
- Code 3021 *Retinal function assessment including refraction after ocular surgery (within four months),* ***maximum two*** *examinations* is chargeable postoperatively e.g. post-op codes for cataract surgery, however, take note of the guidelines and interpretation hereof to prevent rejections:

  - *It is acceptable to use code 3021 after any surgery (which might affect the refraction) for a period of 4 weeks when ocular functional visual assessment is done. This would include a refraction. Can be coding twice within the normal postoperative period (Rule G). Examples are cataract surgery, secondary lens implants, Lasic and others.*
  - *Normal post-operative care including consultations are already included in the surgical procedure global professional units for the time period as mentioned above - thus the consultation, tonometry item 3014, fundus exams, items 3003, 3004, 3009 etc. are already accounted for and cannot be coded again.*
  - *Item 3021 x2 is the only additional code and is part of the surgical procedure.*
  - *When a complication over and above the normal occurs and e.g. Additional examinations and procedures like vitrectomies, resuturing after glaucoma surgery have to be done, then the follow-up procedures/operations can be billed for separately and a new post-operative period would start.*

Kindly note: ***COIDA has post-operative period of 4 months.***

To avoid unnecessary retrospective reversals, take note of the following on delegation of post-operative after-care:

- If the normal after-care is delegated to another registered health professional and not completed by the surgeon, it shall be his/her own responsibility to arrange for this to be done without extra charge.

Rule H – Removal of lesions

Codes involving removal of lesions include follow-up treatment of 10 days.

Rule J – Disproportionately low procedure units (modifier 0014)

In these exceptional cases where the fee is disproportionately low in relation to the actual services rendered by a medical practitioner, a higher fee may be negotiated. An operative report describing the complex nature of the procedure and extended theatre time will be requested. The use of this rule is not intended merely to increase the Medical Schemes Benefits.

Use modifier **0014**: Operations previously performed by another surgeon

- Use modifier 0014 (a) for information only as an indicator that the operation was previously performed by another surgeon.

- Where an operation is performed which has previously been performed by other surgeons, e.g. a revision or repeat operation, the fee shall be calculated according to the tariff for the full operation plus an additional fee to be negotiated under general Rule J. In exceptional cases where the fee is disproportionately low in relation to actual service rendered, except where already specified in the tariff.

Kindly note:
- This would always require an operative report that should detail the complexity nature and extended theatre time of the procedure.
- There is no guarantee that the higher fee will be funded by the medical scheme.
- Members and patients cannot be held liable for these costs.
- It is necessarily negotiated postoperatively with remuneration retrospectively.

Rule L – Procedures performed at time of visits

If a procedure is performed at the time of a consultation/visit, a consultation PLUS the fee for the procedure must be charged.

Rule M – Surgical procedure planned to be performed later

Should a surgical procedure be planned to be performed at a later stage, at the time of a current consultation/visit, a routine pre-operative visit may not be charged for again at such a later occasion, because that routine pre-operative visit is included in the surgical global period for the procedure.

In cases where, during a consultation/visit, a procedure is planned to be performed at a later occasion, a visit may not be charged for again, at such a later occasion.

It would therefore be only in *bona fide* emergency cases where the practitioner is called to hospital, consults the patient for the first time and operates the patient later that day, where the relevant consultation/visit would be chargeable on the same day as the operation.

To avoid unnecessary retrospective reversals, take note of the following:
Elective Procedures
For example: Procedure for Cataract, an initial consultation has taken place, investigative tests done and the date is booked or planned for the procedure.

Separately identifiable consult
Can only bill a consultation if there **is a change in the patient's condition or a significant, separately identifiable consultation took place** by the same physician on the same day and is clearly documented. *(The consultation must be significant; the problem must warrant physician work that is medically necessary)*

3.3 Modifiers governing the billing coding structure

A list of the most commonly utilised modifiers pertaining to the billing coding structure is briefly discussed.

❖ **It is of utmost importance that practitioners read about all the Modifiers in the latest MDCM (full guide)**

Modifier 0004 – Procedures performed in own procedure rooms

(a) Procedures performed in doctors' own procedure rooms instead of in a hospital theatre or unattached theatre unit: units as for the procedure + 100% of the units for the procedure [the units for modifier 0004 equals 100% of the units of the procedure(s) performed].

(b) Modifier 0004 may only be used when the operation/procedure units allocated to **a single procedure**, is higher than **30.00** units.

(c) Please note: Only the medical doctor owning/renting the facility, and the equipment may use modifier 0004. Only one person may use this modifier for procedures performed in doctors' own procedure rooms.

- *Appropriate for use by the doctor who performs procedures, which are **usually performed in theatre**. This modifier is to compensate the medical doctor for accepting the added risk and acquiring the appropriate equipment to perform the procedure in the rooms instead of in a hospital theatre setting.*
- *Modifier 0004 is not applicable to Compensation Fund cases*

Modifier 0005 – Multiple procedures / operations under the same anaesthetic

a) Multiple procedures / operation: Unless where otherwise identified in the structure when multiple procedures/operations add significant time and/or complexity, and when each procedure/operation is clearly identified and defined, the following values shall prevail:

- 100% (full value) for the first or major procedure/operation
- 75% for the second procedure/operation
- 50% for the third procedure/operation
- 25% for the fourth and subsequent procedures/operation
- This modifier does not apply to purely diagnostic procedures

(More detail regarding modifier 0005 can be viewed in the latest MDCM)

Modifier 0008 – Specialist surgeon assistant

The units of the procedure (s) for a specialist surgeon acting as assistant surgeon in procedures of a specialised nature, is 40% of the units for the procedure(s) performed by the specialist surgeon. Modifier 0008 may only be used if the assistance of a specialist assistant is imperative to be able to perform the procedure. If not, this assistant must refer to modifier 0009.

(More detail regarding M0008 is available in the latest MDCM)

Modifier 0009 – Assistant

The fee for an assistant is 20% of the fee of that of a specialist surgeon, with a minimum of **36.00** clinical procedure units. The minimum fee payable **may not be less than 36.00 clinical procedures units.**

Of importance:

- Most billing platforms mandate practice numbers and MP numbers which must be presented on claims.
- If a GP practice number is used against 0008, the line item will most probably be rejected and/or be send for auditing.

Modifier 0010 – Local anaesthesia administered by the operator

(a) Modifier 0010 for local anaesthesia administered by the operator may only be used:
- When an operation or procedure have a value greater than 30.00 clinical procedure units (i.e. 31.00 or more clinical procedure units allocated to a single item) **OR**
- When more than one operation or procedure is done at the same time with a combined value greater than 50.00 clinical procedure units

(b) The units shall be calculated according to the basic anaesthetic units for the specific operation.
- Anaesthetic time may not be added, but the minimum fee as per modifier 0035 shall be applicable in such a case *(Modifier 0035: Anaesthesia administered by an anaesthesiologist/anaesthetist, MDCM 2022)*

(c) Not applicable to radiological procedures (such as angiography and myelography)

(d) Not applicable for **topical application** of local anaesthetic

(e) Modifier 0010 **may not** be added on the surgeon's account for procedures that were performed under general anaesthetic (presence of anaesthetist)

Kindly note: codes 2802 and 2801 are specialist Anaesthetist procedures, often under Ultrasound Guidance like brachial plexus blocks. For Ophthalmology there are already specific Anaesthetist codes related to each procedure. For Ophthalmology the Anaesthetist fee should be charged by either the Anaesthetist (their own codes) or the Surgeon (0010). Unfortunately, not both. If they do share the workload, they can "subcontract" amongst themselves, but both cannot charge for Anaesthetist and overlap.

Modifier 0011 - Emergency procedures

Definition of an emergency:
A medical emergency is any condition where death or irreparable harm to the patient will result if there are undue delays in receiving appropriate medical treatment.

- Any bona fide, justifiable **emergency procedure (all hours)** undertaken in an operating theatre and/or in another setting in lieu of an operating theatre, will attract an additional **12,00 clinical procedure units per half-hour or part thereof** of the operating time for all members of the surgical team.
- Modifier 0011 **does not apply in respect of patients on scheduled lists.**

Modifier 0014 – Operations previously performed by **other surgeons**

Use modifier 0014 as information modifier. It is an indicator that the surgery was performed previously by another surgeon. The units shall be calculated according to the units for the full operation plus additional units to be negotiated under Rule J. See Rule J for more detail.

Modifier 0018 – BMI higher than 35

Calculated according to kg/m2 = weight in kilograms divided by height in metres squared rounded off to the first decimal

- Units for the procedure (including modifiers, except modifier 0011) + 50% of surgeon's units
- Anaesthesiologists / anaesthetists + 50% increase in anaesthetic time units only
- **Kindly note:** Medical schemes may or may not pay for modifier 0018 in which case Rule J can be considered and negotiated.

3.4. Billing of materials (0201), disposables and sterile tray (0202)

Code 0201 - SAMA MDCM guideline

General consumables such as linen, linen savers, cleaning solutions, suction liners and tubing, are included in the equipment items for endoscopy performed with own equipment in office procedural room. Items such as syringes, needles and gloves used during an examination in rooms can be billed under 0201.

The MARK-UP issues.[1]

[1] No rebates/discounts are allowed on Medication – the Single Exit Price (SEP) must be adhered to.

Disclaimer: The following is under review for a legal opinion:

Other material 0201 Mark up: "Reasonable amount" and the practice must be able to explain where the % comes from. Intra ocular lenses (IOL) are also be charged with code 0201. It is appropriate to charge a mark-up for costs incurred and having a lens available in theatre. The mark-up will include the handling fee.

Code 0202 - Sterile tray - SAMA MDCM guideline

A fee of 10,00 clinical procedure units may be charged for the setting of a sterile tray where a sterile procedure is performed in the rooms.
Cost of **stitching material**, if applicable, shall be charged for according to item 0201, with a valid NAPPI code.
This item is a blanket charge to put consumables together or for pre-packed sterile trays used for sterile procedures.

Appropriate to use in the following instances:

- Wound dressing procedures for septic wounds
- Deep skin biopsies by incision and suturing (0237)
- Suturing of wounds (0300 to 0304)
- Hormone implantation (2565, 3001)
- Drainage of an abscess
- Removal of lesions by curetting (e.g. items 0245-0246, 0251-0252)
- Botulinum toxin injection (items 3174, 3175, 6005-6009)
- Excision of Meibomian cyst (item 3171)

NOT appropriate to use in the following instances:

- General examination
- Post-operative follow-up consultation
- Wound care
- Removal of stitches
- Removal of sebaceous gland without procedure
- Cauterisation procedures

Code 0194 – Procurement cost for human donor material

- **No Mark-up is allowed**
- Procurement cost for such as harvesting, preservation, transportation and serology testing e.g. HIV and Hepatitis on donor cornea, sclera, bone or fascia, etc.
- Trading in human tissue is unlawful therefore no item may be used for donor material.
- Please report the type of human tissue on the account.
- Apply Rule C: Comparable service (code 6999) in cases where the medical scheme has not accepted this code yet, like DHMS.

4. Billing Guidelines

4.1. Incorrect Coding Practices (Important principles)

The basic building blocks of a bill are codes viz. ICD-10 Diagnosis Codes, Procedure Codes and Modifiers. Correct codification is most important.

- Bill the most comprehensive procedure to report the service provided.
- When multiple procedures are performed and a code describes all the components of the service, that code must be used instead of multiple component codes
- Be cognisant of what is included and excluded in each code
- Commentaries in the coding guides may indicate scenarios where a code may be applied
- If a code that accurately describes the procedure performed cannot be found, Rule C may be invoked.
- Coding is paramount, from which units (RVU) flow, RCF applied, and rand value generated.
- If the values are deemed too low, Rule J may be invoked.
- The Scheme may then apply their benefit rules to decide what will be paid out to the providers.

4.1.1. Unbundling

Often a main procedure will have several minor procedures. These minor procedures are **incidental or mutually exclusive** to the main procedure.
Because they are sometimes performed alone, they often have their own procedure codes.

To avoid unnecessary retrospective reversals:
Unbundling is seen as fragmented billing for additional remuneration.
Unbundling is when these minor procedure codes are reported in conjunction with a main procedure code to increase the professional fee.

Example

Guidelines:

- An isolated or stand-alone procedure cannot be used in conjunction with a procedure which would normally include the smaller procedure, like 3149 or 3131 in addition to 3047, 3099, etc.:

Code	Description	RVUs	Comment
3047	Cataract: Extra-capsular (including capsulotomy)	**210.00**	**Code only 3047 with 3049**
3049	Insertion of lenticulus in addition to item 3045 or item 3047 (cost of lens excluded) (modifier 0005 not applicable)	57.00	
3149	Iridectomy or iridotomy by open operation as *isolated procedure*	132.00	**Not to be used in addition**
OR			

3099	Posterior vitrectomy including anterior vitrectomy, encircling of globe and vitreous replacement	419.00	**Code only 3099**
3131	Cornea: Paracentesis	53.00	**Not to be used in addition**

4.1.2. Upcoding

Upcoding is when a more complex code is reported to that of the actual procedure performed for additional remuneration

- Often there is a range of several codes for the same type of procedure.
- The codes vary from the simplest format of the procedure to the most complex.
- The remuneration for the procedure typically increases as the complexity increases.
- Providers sometimes claim for a more complex procedure.

Example of upcoding: Codes for intra vitreal treatment (3090 & 3094)

Code 3090: Intra vitreal injection drug is used when only an injection is performed.

Code 3094: Implantation of intra vitreal drug delivery system is used when an intra vitreal drug system device is implanted to provide consistent delivery of a drug.

Both codes may not be charged together for the same eye during the same session since each code represents a different technique for intra vitreal treatment.

If only an injection was performed code 3090 would be applicable:

Claim	Code	Description	RVUs
Correct claim	3090	Intra vitreal injection drug	**47.60**
Up coded claim	***3094***	*Implantation of intra vitreal drug delivery system*	***247.60***
The billing of code *3094* instead of code 3090 adds an extra 200.00 units, effectively increasing the surgical fee over 200%.			

Kindly take note:

If code 3094 is charged, it will attract **Rule G**: Postoperative care (four (4) weeks) and would be recognisable on the accompanied hospital account with the *NAPPI* code describing an intra vitreal drug system with the associated price which will not be applicable if only an intra vitreal drug injection is done, and vice versa.

5. Glossary

AMA	American Medical Association
BHF	Board of Healthcare Funders
CCSA	Complete CPT® for South Africa 2018 Edition
CMS	Council for Medical Schemes
CPIX	Consumer Price Index excluding mortgage cost
CPT	Current Procedural Terminology
NDoH	National Department of Health
HCFA	Health Care Financing Administration
HPCSA	Health Professions Council of South Africa
ICD-10	The International Statistical Classification of Diseases and Related Health Problems, 10th Edition
MDCM	Medical Doctors' Coding Manual
NHRPL	National Health Reference Price List
PLI	Professional Liability Insurance
RBRVS	Resource-Based Relative Value Scale
RPL	Reference Price List
RVS	Relative Value Scale
RVU	Rand Conversion Factor
SAMA	South African Medical Association
SAPPF	South African Private Practitioners Forum
WHO	World Health Organisation

6. Consultation and procedure codes

6.1. Consultations

The SAMA MDCM provides full descriptions and general information pertaining to Consultative Services, as well as providing guidance on code combinations.

6.1.1. In-rooms consultation

CODE	DESCRIPTION	RVU	Scheme RVU
In general, the schemes have not accepted the tiered consultation or visits. (Kindly see Scheme RVU)			
0190	Consultation: New and established patient - rooms; Includes expanded problem focused history, expanded problem focused examination, medical decision making of low complexity, counselling and coordination of care with other medical practitioners / health care professionals. *Low to average duration and/or complexity - up to 15 min face-to-face with patient and/or family*	15.00	17.00
0191	Consultation: New and established patient - rooms; Includes a detailed history, detailed examination, medical decision making of moderate complexity, counselling and coordination of care with other medical practitioners / health care professionals. *Moderately above average duration and/or complexity - 16 to 30 min face-to-face with patient and/or family*	30.00	17.00
0192	Consultation: New and established patient - rooms; Includes a comprehensive history, comprehensive examination, medical decision making of high complexity, counselling and coordination of care with other medical practitioners / health care professionals. *Long duration and/or high complexity - 31 to 45 min face-to-face with patient and/or family*	45.00	17.00
0193	Consultation: New and established patient - rooms; Includes a comprehensive history, comprehensive examination, medical decision making of high complexity, counselling and coordination of care with other medical practitioners / health care professionals. *Long duration and/or high complexity - 46 to 60 min face-to-face with patient and/or family*	63.60	17.00

6.1.2. Sensorimotor examination

- Kindly note: Although funders might not want to pay these codes these are the correct codes to use.

CODE	DESCRIPTION	RVU
3013	Sensorimotor examination: With multiple measurements of ocular deviation; one or both eyes with interpretation and report ** Separate procedure*	19.60
3038	Sensorimotor examination: With multiple measurements of ocular deviation; one or both eyes (e.g. restrictive or paretic muscle with diplopia) with interpretation and report, for **children 7 years and younger** (separate procedure) ** Separate procedure. * Interpretation and report included. * This code may be used for screening of retinopathy of premature babies or babies who weigh less than 2500g at birth.*	45.00

Disclaimer: *The publication is based upon best available information, available to OMG and will not be held responsible for any losses incurred by practitioners resulting from the use of this publication.*

6.1.3. In-Hospital consultations

CODE	DESCRIPTION	RVU	Scheme RVU
In general, the schemes have not accepted the tiered consultation or visits. (Kindly see Scheme RVU)			
0173	First hospital consultation: Includes history, examination and medical decision making that is straightforward or of low complexity. Initial hospital care, per day, for the evaluation and management of a patient. *Average duration and/or complexity after patient has been admitted to the ward - up to 15 min at the bedside and on the patient's hospital floor or unit.*	15.00	17.00
0174	First hospital consultation: Includes a comprehensive history, a comprehensive examination, and medical decision making that is of moderate complexity. Initial hospital care, per day, for the evaluation and management of a patient. *Moderately above average duration and/or complexity after patient has been admitted to the ward - 16 to 30 min at the bedside and on the patient's hospital floor or unit.*	30.00	17.00
0175	First hospital consultation: Includes a comprehensive history, a comprehensive examination, and medical decision making that is of high complexity. Initial hospital care, per day, for the evaluation and management of a patient. *Long duration and/or high complexity after patient has been admitted to the ward - 31 min to 45 min at the bedside and on the patient's hospital floor or unit.*	45.00	17.00
0109	Hospital follow-up visit in ward/nursing facility (once per calendar day) - up to 30 minutes Subsequent hospital care, per day, for the evaluation and management of a patient, which includes an expanded problem focused interval history, an expanded problem focused examination and medical decision making of moderate complexity.	15.00	17.00

6.1.4. Add on consultation services:

ADD ON CONSULTATION SERVICES (ONLY 1 ITEM)
Note: Only one of items 0145, 0146, 0126 or 0147 may be charged and not combinations thereof

Code	Description	RVUs
0126	For an **UNSCHEDULED** consultation at the doctor's rooms: ADD only to the consultation/visit items 0190-0192 (add-on code) • *Item 0126 may only be added to the appropriate consultation/visit (item 0190-0193) for an unscheduled consultation/visit at doctor's rooms or home* • *Only one of items 0145, 0146, 0126 or 0147 may be added to a consultation/visit item, as appropriate, and not combinations thereof* • *Not appropriate to add to items 1204-1210* • *The patient is responsible for the payment if his/her medical scheme does not grant benefits for this service* • *Practices where no bookings or scheduling of appointments are done, and patients are seen on a first come, first served basis, may not use item 0126*	8.00

0129	Prolonged attendance to a patient and/or family: ADD to either item 0193 or 0175 (as appropriate), for each 15-minute period only if service extends 10 minutes or more into the next 15-minute period following on the first 60 min (***minimum of 70 min consultation***) (add-on code) *• Item 0129 may only be added to item 0193 or item 0175 as appropriate, for consultations with a duration longer than 60 minutes (The consultation must extend more than 10 minutes – into the first 15 minutes period).*	15.00
0145	For consultation AWAY from the medical doctor's rooms (non-emergency): ADD only to the consultation items 0190-0193, items 0173-0175, or item 0109 as appropriate. (add-on code) *• This code can be billed with a visit **away from the doctors' rooms when the visit is not an emergency.*** *• Only one of items 0145, 0146, 0126 or 0147 may be added to a consultation/visit item, (as appropriate) and not combinations thereof* *• To be added to items 0190-0193, 0173-0175 (as appropriate) for a non-emergency visit away from the consulting rooms or doctor's home* *• Refer to Rule Q(a) for first hospital visit in Intensive Care/High Care unit after same-day initial visit in rooms* *• The patient is responsible for the payment if his/her medical scheme does not grant benefits for this service*	6.00
0146	For an EMERGENCY consultation AT the medical doctor's rooms: ADD only to the consultation items 0190-0193 *• This code is **only covered** for an unscheduled **emergency** and not in the case where the consultation was just unscheduled.* *• Refer to item 0126 for UNSCHEDULED consultation/visit at doctor's rooms or home* *• Only one of items 0145, 0146, 0126 or 0147 may be added to a consultation/visit item, as appropriate, and not combinations thereof* *• To be added to items 0190-0193 (as appropriate) for emergency consultations in rooms* *• To be added to items 0190-0193 (as appropriate) for consultations by doctors normally using 24-hour emergency facilities* *• The patient is responsible for the payment if his/her medical scheme does not grant benefits for this service (not applicable to Compensation Fund cases)*	8.00
0147	For an **EMERGENCY** or UNSCHEDULED consultation AWAY from the medical doctor's rooms, all hours: ADD only to the consultation items 0173-0175 (add-on code) *• Only one of items 0145, 0146, 0126 or 0147 may be added to a consultation/visit item, as appropriate, and not combinations thereof* *• To be added to items 0190-0193, 0173-0175, 0161-0164, 0166-0169 or 0151-0153 (as appropriate) for an emergency visit away from the consulting rooms or doctor's home* *• Not to be added to items 0190-0193 for consultations by doctors normally using 24-hour emergency facilities* *• Not to be added to items 1205-1210* *• The patient is responsible for the reimbursement if his/her medical scheme does not grant benefits for this service (Not applicable to Compensation Fund cases)*	14.00
See **modifier 0011** for the definition of an emergency.		
0148	For elective after-hours services on request of the patient of family (non-emergency): ADD only to the consultation items 0190-0193 (add-on code) *• Elective after hours is not covered by any scheme and is for the members own expense.* *• To be added to items 0190-0193, 0173-0175 (as appropriate) when a non-emergency consultation/visit is made at request of the patient or patient's family (not applicable to Compensation Fund cases)*	

	• *The value of this item is 50% of the appropriate consultation/visit item* • *The patient is responsible if his/her medical scheme do not grant benefits for this service* ***Usage:*** *This item is used when, for example, a patient or the family request the doctor for a non-emergency consultation/visit outside of the normal hours period as reflected in general rule B.*	
0149	After-hours bona fide emergency consultation/visit (21:00-06:00 daily): ADD only to the consultation items 0190-0193 (add-on code) • *Only Item 0149 may only be added to the appropriate consultation/visit item (only to be used with items 0190-0193, items 0173-0175 for emergency consultation/visit between 21:00 – 06:00 (not applicable to Compensation Fund cases)* • *Item 0149 is not appropriate for 24-hour emergency facilities* • *The value of this item is 25% of the appropriate consultation/visit item* • *The patient is responsible for the payment if his/her medical scheme do not grant benefits for this service*	
0178	Hospital follow-up visit in ward with duration of **31 to 60** min: **ADD to item 0109** (add-on code)	15.00
0179	Prolonged face-to-face hospital follow-up visit in ward: ADD to item 0178 for each 15 min period following the **first 60 min** (add-on code)	15.00

6.1.5. Miscellaneous consultation services

MISCELLANEOUS CONSULTATION SERVICES **Not chargeable with any consultation item**		
0130	Telephone evaluation and management service by a medical practitioner who may report evaluation and management services provided to an established patient not originating from a related emergency / medical service provided within the previous 7 days, nor leading to an emergency / medical service or procedure within the next 24 hours or soonest available appointment	12.00
0131	Subsequent injections as part of a planned series of injections for the same condition administered by medical doctor. • *Not chargeable with any consultation item*	7.50
0132	Consulting service: writing of repeat script / requesting routine pre-authorisation without the physical presence of the patient (via sms or electronic media included) • *Patients are personally liable for these accounts if not covered by their medical scheme benefits.*	5.00
0133	Writing of special motivations for procedures and treatment without the physical presence of a patient (includes report on the clinical condition of a patient) requested by or on behalf of a third-party funder or its agent • *Patients are personally liable for these accounts if not covered by their medical scheme benefits.* **The preparation of medico-legal reports:** • The South African Medical Association (SAMA) does not recommend fixed remuneration for the preparation of medico-legal reports, nor does it recommend an average code. Remuneration vary widely and depend on the experience of the assessing doctor in preparing these reports; the length of time that it has taken the doctor to examine the patient. This depends on the number of injuries and the severity of the injuries; and the time that it takes to prepare the report. Therefore,	9.00

	it is impossible to lay down a fixed remuneration for this type of work. It is however, suggested that a doctor calculate his gross hourly income by using his gross annual income and deducting a period of six (6) weeks for absence, and then uses that as an hourly cost.	
0137	Patient and/or family education and/or guidance for specific condition for 20 minutes (ICD-10 codes to be added for this service) *• Item 0137 is only appropriate when patient education is done for a specific condition* *• It is appropriate to use item 0137 in conjunction with a consultation item*	15.00
0138	Patient and/or family education and/or guidance for specific condition for 40 minutes (ICD-10 codes to be added for this service) *• Item 0138 is only appropriate when patient education is done for a specific condition* *• It is appropriate to use item 0138 in conjunction with a consultation item*	30.00
0139	Patient and/or family education and/or guidance for specific condition for 41 minutes or longer (ICD-10 codes to be added for this service) *Item 0138 is only appropriate when patient education is done for a specific condition* *• It is appropriate to use item 0138 in conjunction with a consultation item*	45.00
0199	Completion of chronic medication forms by medical doctors with or without the physical presence of the patient *• Patients are personally responsible for payment of accounts for this item if not covered by their medical scheme benefits.*	21.43

Eye: General information

Optic nerve decompression:	• Item 2831 with Rule C (refer to item 6999) is appropriate for an optic nerve decompression
Ultrasound before cataract surgery	• It is appropriate to code item 3632, per eye, prior to cataract extraction and lens insertion
Use of own microkeratome	• The use of item 3126 with item 3128 is not allowed • Item 3126 may be used in conjunction with item 3120 if own microkeratome is used
Use of own diamond knife in cataract procedures	• Use of 3129 is not applicable for cataract procedures
Refractive keratectomy with Excimer laser	• Item 3120 is the procedure item when a refractive keratotomy is performed with Excimer laser and is coded per eye • If appropriate, the equipment hire for the Excimer laser (item 3198) is added to item 3120 • If the procedure is performed in the doctor's own facility with hired equipment, use item 3198 according to specifications • If the hospital/institution, where the procedure is performed, code for the use of the Excimer laser, the doctor may not use item 3198 merely for the fact that the procedure was performed with an Excimer laser
Indications for therapeutic refractive surgery	• Excimer laser should be funded for myopia equal to or more than -3 dioptres and / or astigmatism equal to or more than -2.5 dioptres • Regarding hyperopia, funding should be available for refractive errors equal to or more than +2 dioptres • Phakic IOL's could be indicated in myopia of more than -6 dioptres. PIOL's are particularly indicated where the cornea is too thin for laser treatment. In high myopes above -12 dioptres the implants are effective in rendering a better visual result • In hyperopia PIOL's should be funded for refractive errors equal to or more than +4 dioptres

Steroid injections	• No code is coded for retrobulbar and steroid injections administrated during operations • A code is coded for steroid injections administered during the postoperative period
Eye investigations and photography	• Items for eye investigations and photography cover both eyes unless otherwise stated • No extra code is coded if the second eye is examined at a later stage • Material is excluded • The code for photography is not related to the number of photographs taken • No code is coded for storage, cartridges, etc.
Eye investigations by general practitioners:	• General practitioners, who perform eye investigations in their rooms, should motivate the reason for the services and indicate the type of equipment used as well as the results of the tests they performed • Non-ophthalmologists are not entitled to code separately for equipment used in eye investigations e.g. ophthalmoscope (item 3004)
Tonometry	• Item 3014 appropriate for a pressure test of the eye • Use item 3014 when provocative tonometry is performed. A maximum of two test may be done • A retinal threshold test (item 3017) does not include tonometry
Consultations after therapeutic procedures	• In terms of Rule G no consultation item can be coded in the postoperative period • Item 3021 may however be coded within the postoperative period for, amongst others, refraction assessment after ocular surgery (with a maximum of two examinations)
General anaesthetic for eye procedures	• Modifier 0005 is applicable to eye procedures done on both eyes and performed under general anaesthetic
Local anaesthetic for eye procedures	• Where eye procedures are performed under local anaesthetic, the full units are applicable for each procedure unless otherwise stated in the coding structure
Occlusion of nasolacrimal ducts	• The ophthalmology Society of SA is of the opinion that occlusion of nasolacrimal ducts should only be performed by ophthalmologists (Pr"26")
Note: a. Eye investigations and photography refer to both eyes except where otherwise indicated. No extra item may be coded where each eye is examined separately on two different occasions. b. Material used is excluded. c. The cost of photography is not related to the number of photographs taken	

ROP: Billing guidelines for Retinopathy of Prematurity screening

The South African Vitreoretinal Society has compiled a list of codes which we feel are appropriate to bill when screening a premature baby for ROP. Please note that 3038 has formally been accepted by SAMA for the ROP screening basket. The interpretations will change in the 2025 MDCM to: *This code may be used for screening of retinopathy of premature babies or babies who weigh less than 2500g at birth.*

In hospital	In the doctors rooms
• 0173 (first hospital visit) or 0109 (follow up visit) • 0145 or 0147 • 3038 • 3004 • 3014 *when intraocular pressure is measured to exclude glaucoma*	• 0190 • 3038 • 3009 • 3004 • 3014 *when intraocular pressure is measured to exclude glaucoma*

6.2. Procedures

Integumentary systems

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
0251	Removal of malignant lesions by curetting under local or general anaesthesia followed by electrocautery: First lesion	30.00	0005	0010	0252	
+ 0252	Removal of malignant lesions by curetting under local or general anaesthesia followed by electrocautery: Subsequent lesions (each)	7.00		0005 0010		To be used in conjunction with 0251 only

Eye Investigations

CODE	DESCRIPTION	RCF	NOTES
3002	Gonioscopy	7.00	

CODE	DESCRIPTION	RCF	NOTES
3003	Fundus contact lens or 90 D lens examination (not to be charged with item 3004 or item 3012)	7.00	
3004	Peripheral fundus examination with indirect ophthalmoscope (not to be charged with item 3003 and/or item 3012)	7.00	*• Item 3004 forms part of a neurological examination and may only be used by ophthalmologists (Pr"26")*
3006	Keratometry	7.00	
+ 3009	Basic capital equipment used in own rooms by ophthalmologists. Only to be charged at first and follow-up consultations. Not to be charged for post-operative follow-up consultations	11.68	
3012	Pre-surgical retinal examination before retinal surgery	32.00	
3013	Sensorimotor examination: With multiple measurements of ocular deviation; one or both eyes with interpretation and report	19.60	*•Separate procedure.*
3038	Sensorimotor examination: With multiple measurements of ocular deviation; one or both eyes (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (stand-alone procedure) for children 7 years and younger	45.00	*•Stand-alone procedure.* *•Interpretation and report included* *• For examination of patients of above age of 7 years, refer to code 3013.* *• This code may be used for screening of retinopathy of premature babies or babies who weigh less than 2500g at birth.*
3014	Tonometry per test with maximum of 2 tests for provocative tonometry (one or both eyes)	7.00	*• Item 3014 is appropriate for a pressure test of the eye* *• A retinal threshold test (item 3017) does not included tonometry* *• Appropriate for a maximum of 2 tests if provocative tonometry is done* *• Appropriate for one or both eyes and may only be coded once*
3021	Special eye investigations: Retinal function assessment including refraction after ocular surgery (within four months), maximum two examinations	9.00	1. *It is acceptable to use item 3021 after any ocular surgery (which might affect the refraction) for a period of 4 weeks (COID 4 months) when ocular functional visual assessment is done. This could include a refraction. Can be coded only twice within the normal postoperative period (Rule G). Examples are cataract surgery, secondary lens implants, Lasik and others. The descriptor in the MDCM defines the scope of this code.* 2. *Normal postoperative care including consultations are already included in the surgical procedure global professional units for the time period as mentioned above* – ***thus the consultation, tonometry item 3014, fundus exams, items 3003, 3004, 3009 etc. are already accounted for and cannot be coded again.*** 3. *Item 3021 x2 is the only additional code and is part of the surgical procedure* *4. When a complication over and above the normal occurs and e.g. Additional examinations and procedures like vitrectomies, resuturing after glaucoma surgery have to be done, then the follow-up procedures/operations can be billed for separately and a new postoperative period would start.*

Special Eye Investigations

CODE	DESCRIPTION	RCF	NOTES
3005	Endothelial cell count	7.00	
3007	Potential acuity measurement	7.00	
3008	Contrast sensitivity test	7.00	
3010	Orthoptics consultation	10.00	• *Entails prescribing and training the patient to perform exercises to correct ocular problems most frequently ocular muscle imbalances e.g. repetitive tasks with prisms; colour cards or rods*
3011	Orthoptic subsequent sessions	5.00	
3015	Charting of visual field with manual perimeter	28.00	
3016	Retinal threshold test without storage facilities	30.00	
3017	Retinal threshold test inclusive of computer disc storage for Delta of Statpak programs	74.00	• *Tonometry is not included in item 3017*
+ 3018	Retinal threshold trend evaluation (additional to item 3017)	16.00	• *Should be preceded by 3017*
3019	Ocular muscle function with Hess screen or perimeter	16.00	
3020	Special eye investigations: Pachymetry: Only when own instrument is used, per eye. Only in addition to corneal surgery	46.00	
3022	Digital fluorescein video angiography	68.00	• *Add item 3024, if applicable* • *May be added to item 3023*
3023	Digital indocyanine video angiography	110.00	• *Add item 3024, if applicable* • *May be added to item 3022*
+ 3024	Infusion of dye used during Fluorescein Angiography, Indocyanine Green Video Angiography and Photodynamic therapy. Linked to items 3022, 3023, 3031, 3039	12.00	• *Add item 3024, if applicable to 3022, 3023, 3031, 3039.*
3025	Electronic tonography	19.00	
3026	Digital Tomography of optic nerve with Scanning Laser Ophthalmoscope (SLO). Limited to two exams per annum	19.30	• *Item 3026 is appropriate for examination of one or both eyes at the same session.*
3027	Fundus photography	21.00	• *Item 3027, may only be used by ophthalmologists (Pr"26")* • *Appropriate to add item 0201 for film and development cost*
3028	Optical Coherent Tomography (OCT) of Optic nerve or macula: Per eye	40.00	
3030	**Optical Coherence Tomography (OCT) angiography (per eye)**	**11.90**	• *May be coded with 3028 when performed.*
3029	Anterior segment microphotography	21.00	
3031	Fluorescein Angiography: One or both eyes (not to be used with item 3022)	45.00	• *Appropriate for one or both eyes* • *Colour photography excluded* • *If personally performed by the ophthalmologist, no separate item is coded for the interpretation*

			• *Disposable materials used are excluded* • *Add item 3024, if applicable*
CODE	**DESCRIPTION**	**RCF**	**NOTES**
3032	Eyelid and orbit photography	9.00	• *Disposable material used is excluded*
3033	Interpretation of items 3022, 3023 and 3031 referred by other clinicians	16.00	• *This item is for interpretation of the procedure only when referred by another clinician/doctor*
3034	Determination of lens implant power per eye	15.00	• *Item 3034 may **NOT** be used in conjunction with items 3631: Ophthalmic examination and 3632: Axial length measurement and calculation of intra-ocular lens power: Per eye*
+ 3035	Where a minor procedure usually done in the consulting rooms requires a general anaesthetic or use of an operating theatre, an additional fee may be charged Anaesthetic: As per procedure	22.00	• *A motivation is required when item 3035 is used* • *Appropriate for procedures on children e.g. Meibomian's cyst; removal of sutures*
3036	Corneal topography: For pathological corneas only on special motivation. For refractive surgery - may be charged once pre-operative and once post-operative per sitting (for one or both eyes)	36.00	• *Rule G is not applicable as aftercare is not included in item 3036*
3040 (ZT)	Femtosecond Laser: Equipment hire. For one or both eyes done in one session		• *Temporary codes are marked with a "T" in the far-left corner column where the utilisation of the item is not set therefore values will have to be negotiated by the discipline utilising the item.* • *Code only once per session regardless of whether for one or both eyes.*

Retina

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDUR	NOTES
3037	Surgical treatment of retinal detachment including vitreous replacement but excluding vitrectomy	306.90	0005	0010	3201	• *Items 3037 and 3099 are two separate operations and may therefore be coded together when appropriate.* • *Modifier 0005 should be used.*
3039	Prophylaxis and treatment of retina and choroid by cryotherapy and/or diathermy and/or photocoagulation and/or laser per eye (aftercare excluded)	105.		0010	3024 3201	• *Add item 3024, if applicable* • *Rule G is not applicable as aftercare is not included in item 3039*
3041	Pan retinal photocoagulation (per eye): Done in one session (aftercare excluded)	150		0010	3201	• *Rule G is not applicable as aftercare is not included in item 3041*
3044	Removal of encircling band and/or buckling material	105	0005	0010		

Cataract

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3045	Cataract: Intra-capsular	210	0005	0010	3049 3202	3049 to be used in conjunction for insertion of intraocular lens (modifier 0005 not applicable)
3047	Cataract: Extra-capsular (including capsulotomy)	210	0005	0010	3049 3202	• 3049 to be used in conjunction for insertion of intraocular lens (modifier 0005 not applicable)
+ 3049	Insertion of lenticulus in addition to item 3045 or item 3047 (cost of lens excluded) (modifier 0005 not applicable)	57		0005 0010		• To be preceded by either 3045 or 3047 for complete one-stage procedure
3048	**Digital Toric Marking**	**35**				*• Motivation may be requested on application received.* *• Applicable to extra consult time, planning time, and administrative burden when a toric IOL is to be used.*
3053	**Surgical wavefront Aberrometer Equipment e.g. Callisto Machine**	**35**				*• Equipment code: Used "per eye" when equipment is required for the use in Toric intraocular Lens implants*
3050	Repositioning of intra ocular lens	171.1	0005	0010		
3051	Needling or capsulotomy	130	0005	0010		
3052	Laser capsulotomy (aftercare excluded)	105		0010	3201	*• Rule G is not applicable as aftercare is not included in item 3052*
3057	Removal of lenticulus	210	0005	0010	3202	
3058	Exchange of intra ocular lens	236	0005	0010		
3059	Insertion of lenticulus when item 3045 or item 3047 was not executed (cost of lens excluded)	210	0005	0010		
+ 3060	Use of own surgical microscope for surgery or examination (not for slit lamp microscope) (for use by ophthalmologists only)	4		0005 0010		

Glaucoma

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3061	Drainage operation	247.60	0005	0010	3062	**More information on code:** • Performed to create a new pathway for fluids in the eye, the surgeon makes an incision in the conjunctiva near the limbus (the corneal-scleral juncture) using a trephine to remove a circular portion of sclera and iris. • The incision is closed with sutures and may restore the intraocular pressure with an injection of water or saline which forms an integral work component of the procedure. • A topical antibiotic or pressure patch may be applied.
+ 3062	Implantation of aqueous shunt device/seton in glaucoma (additional to item 3061)	60		00050 010		• *Modifier 0005 not applicable*
3063	Cyclocryotherapy, cyclodiathermy **or cyclophotocoagulation**	105	0005	0010		**More information on code:** • The ciliary body supplies the anterior chamber with aqueous humor. • Where high intraocular pressure cannot otherwise be controlled, portions of the ciliary body are destroyed with diathermy (cyclodiathermy) or transscleral cyclophotocoagulation to reduce the production of aqueous humor.
3064	Laser trabeculoplasty	105		0010		*• Rule G is not applicable as aftercare is not included in item 3064* **More information on code:** • The surgeon uses argon laser to selectively burn the ring of meshlike tissue at the iris-scleral junction (the trabecular meshwork) to improve the drainage of fluids in the anterior segment. • No incision is made in this procedure.
3065	Removal of blood from anterior chamber	105.00	0005	0010		
3067	Goniotomy	210.00	0005	0010		**More information on code:** • Another technique to improve the drainage of fluids in the eye is through an incision into the anterior chamber and across the anterior to the opposite limbus with a sweep to open the angle or the ring of meshlike tissue at the iris-scleral junction (the

						trabecular meshwork) of the opposite portion of the eye. • De Vincentiis and Barkan's operations are both goniotomy procedures.

Intra-Ocular Foreign Body

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3071	Intra-ocular foreign body: Anterior to Iris	127.00	0005	0010		
3073	Intra-ocular foreign body: Posterior to Iris (including prophylactic thermal treatment to retina)	210.00	0005	0010		

Strabismus

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3074	Strabismus (whether operation performed on one eye or both): Adjustment of sutures if not done at the time of the operation. For use of sterile tray add item 0202	20.00	0005	0010		*• Item 3074* ***may be used in conjunction with item 3075 or 3076***
3075	Strabismus (whether operation performed on one eye or both): Operation on one or two muscles	175.60	0005	0010		*• Item 3075 may not be used in conjunction with item 3074 and item 3076*
3076	Strabismus (whether operation performed on one eye or both): Operation on three or four muscles	200.00	0005	0010		*• Item 3076 may not be used in conjunction with item 3075*
3077	Strabismus (whether operation performed on one eye or both): Subsequent operation one or two muscles	120.00	0005	0010		
3078	Strabismus (whether operation performed on one eye or both): Subsequent operation on three or four muscles	150.00	0005	0010		

Globe

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3079	Transscleral biopsy	132.00	0005	0010		
3080	Examination of eyes under general anaesthetic where no surgery is done	80.00		0005 0010		• *Item 3080 may not be used in conjunction with items 3002, 3004, 3012, 3014, 3021 or 3133*
3081	Treatment of minor perforating injury	161.60	0005	0010		
3083	Treatment of major perforating injury	267.50	0005	0010		
3085	Enucleation or Evisceration	105.00	0005	0010		• *Item 3085 may not be used in conjunction with item 3087*
3087	Enucleation or Evisceration with mobile implant: Excluding cost of implant and prosthesis	160.00	0005	0010	3088	• *Item 3087 may not be used in conjunction with item 3085*
3088	Hydroxyapetite insertion (additional to item 3087)	40.00		0005 0010		• Use item 3088 in conjunction with item 3087
3089	Subconjunctival injection if not done at time of operation	10.00	0005	0010		• Not to be used at the time of operation on eye
3090	Intra vitreal injection drug	47.60	0005	0010		• *Modifier 0004 may be **added once** to item 3090 per session when the intra-vitreal injection drug is being administered in the doctor's rooms*
3091	Retrobulbar injection (if not done at time of operation)	16.00	0005	0010		• Not to be used at the time of operation on eye – see notes at general information.
3092	External laser treatment for superficial lesions	53.00	0005	0010	3114	• Use code 3114 for the equipment component of external laser treatment for superficial lesions prior to LASIK surgery (3120)
3093	Treatment of tumours of retina or choroid by radioactive plaque and/or diathermy and/or cryotherapy and/or laser therapy and/or photocoagulation	209.00	0005	0010		
3094	Implantation of intra vitreal drug delivery system	247.60	0005	0010		• Not to be used with 3090 which represents only a different technique for intra vitreal treatment

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3095	Biopsy of vitreous body or anterior chamber contents	105.00	0005	0010		• Not to be used in conjunction with 3131
3096	Adding of air or gas in vitreous as a post-operative procedure or pneumo-retinopexy	130.00	0005	0010		
3097	Anterior vitrectomy	280.00	0005	0010	3203	
3098	Removal of silicon from globe	280.00	0005	0010	3203	
3099	Posterior vitrectomy including anterior vitrectomy, encircling of globe and vitreous replacement	419.00	0005	0010	3100 3203	• *Items 3037 and 3099 are two separate operations and may therefore be coded together when appropriate.* • *Modifier 0005 should be used.*
3100	Lensectomy done at time of posterior vitrectomy	30.00	0005	0010		

Orbit

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3101	Drainage of orbital abscess	105.00	0005	0010		
3103	Orbit: Removal of tumour	240.00	0005	0010		
3104	Removal orbital prosthesis	212.70	0005	0010		
3105	Orbit: Exenteration	275.00	0005	0010		• An appropriate code for skin graft may be used in conjunction when performed. • If muscle or myocutaneous flap is required, code 0290 would be appropriate as the main procedure together with exenteration code 3105.
3107	Orbitotomy requiring bone flap	393.00	0005	0010		

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3108	Eye socket reconstruction	206.00	0005	0010		
3109	Hydroxyapetite implantation in eye cavity when evisceration or enucleation was done previously	300.00	0005	0010		**More information on code:** • The porous hydroxyapatite implant can be directly coupled with the artificial eye some months after insertion to improve movement by means of a small peg. • This fits into a hole drilled through the conjunctiva (the pink membrane which lines the socket) and into the buried implant. • The conjunctiva then grows down the sides of this drilled hole. This occurs because the implant by then contains blood vessels that support growth of this tissue.
3110	Second stage hydroxyapetite implantation	110.00	0005	0010		**More information on code:** • This secondary procedure is only undertaken for patients in whom the degree of movement of the artificial eye is deemed unsatisfactory following the first stage of hydroxyapetite implantation. • According to recent literature, presently, the second stage is rarely required.

Cornea

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3111	Contact lenses: Assessment involving preliminary fittings and tolerance visits (costs of lenses borne by patient)	0		0005 0010		*• Cost of contact lenses not included*
3112	Fitting of contact lens for treatment of disease including supply of lens. Bandage lens in pathological corneal conditions such as: corneal erosion, ulcer, abrasion or corneal wound	12.20		0005 0010		
3113	Fitting of contact lenses and instructions to patient: Includes eye examination, first	200.00		0005 0010		

	fitting of the contact lenses and further post-fitting visits for one (1) year					
CODE	**DESCRIPTION**	**RVU**	**VALID MODIFIER**	**INVALID MODIFIER**	**ADD-ON FOR PRIMARY PROCEDURE**	**NOTES**
+ 3114	Wavefront analysis (Aberometry) for customized ablation of pathological corneas prior to LASIK surgery - EQUIPMENT component only	78.85		0005 0010		• This is the equipment component of 3092 which should only be used in conjunction with 3120.
3115	Fitting of only one contact lens and instructions to the patient: Eye examination, first fitting of the contact lens and further post-fitting visits for one year included	166.00		0005 0010		
3116	Astigmatic correction with T-cuts or wedge resection in pathological corneal astigmatism following trauma, intra ocular surgery or penetrating keratoplasty	135.20	0005	0010		
3117	Removal of foreign body: On the basis of fee per consultation	Consult ation fee		0005		*• Only a consultation is appropriate for removal of foreign body from cornea*
3118	Curettage of cornea after removal of foreign body (after-care excluded)	10.00	0005	0010		• Consultation fee should be charged for removal of foreign body from the external eye; conjunctival superficial or embedded (includes concretions), subconjunctival, or scleral non-perforating.
3119	Tattooing	26.00	0005	0010		**More information on code**: • Code 3119 involves multiple punctures of anterior cornea (e.g., for corneal erosion, tattoo)
3120	Excimer laser (per eye) for refractive keratectomy or Holmium laser thermo-keratoplasty (LTK) (For machine hire fee for LTK: Use item 3201)	150.00	0005	0010	3114 3126 3190 3198 3201	*• Appropriate if refractive keratotomy is performed with Excimer laser and is coded per eye* *• Item 3198 is appropriate for machine hire if the procedure is performed in the doctor's own facility /hired equipment* *• If the hospital/institution, where the procedure is performed, code for the use of the Excimer laser, the doctor may not use item 3198 merely for the fact that the procedure was performed with an Excimer laser* *• Appropriate to add item 3126 for the use of own microkeratome used with Excimer laser*
3121	Corneal graft (Lamellar or full thickness)	289.00	0005	0010		

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3122	Epikeratophakia	289.00	0005	0010		**More information on code:** Epikeratoplasty (or epikeratophakia) is considered medically necessary for the following indications *(Ref Aetna International Health Insurance)*: • The treatment of childhood aphakia since contact lenses are difficult for children to use and intraocular lens implants may result in long-term complications in children; • The treatment of scarred corneas and corneas affected with endothelial dystrophy; • The treatment of adult aphakia in circumstances where secondary implantation of an intra-ocular lens is not feasible because re-entering the eye could affect outcome (e.g., vitreous in the anterior chamber, history of uveitis, disorganized anterior chamber that cannot support an intraocular lens, significant corneal endothelial disease, or gross corneal irregularity after trauma). • This procedure is considered investigational for correction of refractive errors and for all other cases of adult aphakia.
3123	Insertion of intra-corneal or intrascleral prosthesis for pathological cornea	470.80	0005	0010		• *Item 3123 may not be used in conjunction with items 3132 or 4985* **More information on code:** • Represents keratoplasty in which corneal tissue from a donor is reshaped and transplanted into the corneal stroma of the recipient to modify refractive error.
3124	Removal of corneal stitches under microscope (maximum of 2 procedures). For use of sterile tray add item 0202	9.00	0005	0010		
3125	Keratectomy	127.00	0005	0010		*• Appropriate if the lesion stretches into the stroma of the cornea and is removed by way of partial excision or lamellar corneal excision.* *• Item 3125 is not appropriate with item 3130 except in multiple pathology where additional documentation regarding the indications to use both items should accompany the account* *• Refer to item 3136 for conjunctival flap* **More information on code:** • Represents removal of corneal lesion. • Sutures are not required.

						• Antibiotic ointment and possibly a 24-hour pressure patch is applied. • The cornea is not perforated by the excision.
CODE	**DESCRIPTION**	**RVU**	**VALID MODIFIER**	**INVALID MODIFIER**	**ADD-ON FOR PRIMARY PROCEDURE**	**NOTES**
+ 3126	Additional to item 3120 for the use of own microkeratome used with a excimer laser	52.18		0005 0010		*• Not applicable in addition to item 3128: radial keratotomy or keratoplasty* *• May be coded in addition to 3120: Excimer laser (per eye) for refractive keratotomy or Holmium laser thermokeratoplasty for the use of own microkeratome*
3127	Cauterisation of cornea (by chemical, thermal or cryotherapy methods)	10.00	0005	0010		
3128	Radial keratotomy or keratoplasty for astigmatism (cosmetic unless medical reasons can be proved)	150.00	0005	0010	3129	*• Appropriate to add item 3129 for use of own diamond knives*
+ 3129	Additional to item 3128 for the use of own diamond knives	40.00		0005 0010		*• Not applicable in cataract operations* *• Appropriate in addition to item 3128 for use of own diamond knives*
3130	Pterygium or conjunctival cyst or conjunctival tumour. No conjunctival flap or graft used	96.90	000 5	0010		*• Appropriate as the standard procedure for pterygium or conjunctival cyst or tumour* *• Not appropriate with item 3125 except in multiple pathology where additional documentation regarding the indications to use both items should accompany the account*
3131	Cornea: Paracentesis – stand-alone procedure	53.00	0005	0010		*• Item 3131 is a separate procedure and is a 'stand-alone' item* *• A stand-alone procedure is typically a component of a main procedure. However, it may under certain circumstances, be performed on its own. Therefore, a dedicated code is assigned to this procedure*
3132	Lamellar keratectomy for refractive surgery (LK, ALK, MLK)	150.00	0005	0010		• Code 3132 could be regarded as cosmetic and represents removal of a disk of corneal tissue from the patient for reshaping to correct a refractive error. • Not to be used together with 3120.
3134	Pterygium or conjunctival cyst or conjunctival tumour. Conjunctival flap or graft used - stand -alone procedure	116.30	0005	0010		*• Appropriate for an amniotic membrane transplant* *• A stand-alone procedure is typically a component of a main procedure. However, it may under certain circumstances, be performed on its own. Therefore, a dedicated code is assigned to this procedure.*

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3136	Conjunctival flap or graft (not for use with pterygium surgery)	95.70	0005	0010		• *Appropriate when a conjunctival flap is dissected completely from superior or inferior and implanted over whole cornea*
3138	Removal corneal epithelium and chelating agent for band keratopathy	69.50	0005	0010		
4980	Corneal transplant: Endothelial	274.80	0005	0010		
+ 4981	Preparation of corneal endothelial allograft prior to transplantation (backbench)	0		0005 0010		
4985	Corneal cross linking	150.00	0005	0010		
4986	Corneal cross-linking equipment hire	54.00				

Ducts

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3133	Probing and/or syringing, per duct	10.00	0005	0010		
3135	Insert polythene tubes/ stent: Unilateral. Additional	51.80	0005 0010			
3137	Excision of lacrimal sac: Unilateral	132.00	0005 0010			
3139	Dacrocystorhinostomy (Single) with or without polythene tube	210.00	0005	0010		
3141	Sealing Punctum surgical or by cautery: Per eye	24.90		0005 0010		• *Modifier 0005 is not applicable to as no aftercare is included in this procedure*
3142	Sealing Punctum with plugs: Per eye	20.00		0005 0010		• *Modifier 0005 is not applicable to as no aftercare is included in this procedure*

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3143	Three-snip operation	10.00	0005	0010		**More information on code:** • Tears produced by the lacrimal gland are eliminated through the lacrimal punctum, a small opening in the inner canthus. • Sharp scissors are used to snip the lacrimal punctum, usually posteriorly. A dilating probe is introduced to ensure enlargement of the punctum has been achieved.
3145	Repair of caniculus: Primary procedure	132.00	0005			**More information on code:** • Lacrimal canaliculi are the ducts that carry the tears from the lacrimal gland where they are produced to the nose. • The surgeon uses a probe to locate the distal and proximal ends of the canaliculi in the injured eye of the patient. The ends are freshened and reattached with sutures.
3147	Repair of caniculus: Secondary procedure	175.00	0005			

Iris

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3149	Iridectomy or iridotomy by open operation as isolated procedure	132.00	0005	0010		• Not to be used in conjunction with any other procedure.
3151	Excision of iris tumour	185.00	0005	0010		
3153	Iridectomy or iridotomy by laser or photocoagulation as isolated procedure (maximum one procedure)	105.00	0005	0010		• Not to be used in conjunction with any other procedure. • *Maximum one procedure* **More information on code:** • Involves placement of a special contact lens on the eye, where after the argon or YAG laser is focused on the iris and multiple short bursts of laser light create holes in the iris which allow fluids in the eye to pass from behind the iris through the openings into the space between the iris and the cornea (the anterior chamber). This lowers intraocular pressure.

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3155	Iridocyclectomy for tumour	266.00	0005	0010		
3157	Division of anterior synechiae as isolated procedure	132.00	0005	0010		• For complete severing of adhesions of anterior segment of eye, code 3157 may not to be used together with any other code.
3158	Repair iris as in dialysis: Anterior chamber reconstruction	142.40	0005	0010		

Lids

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3161	Tarsorrhaphy	47.00	0005			**More information on code:** • Tarsorrhaphy involves creating marginal adhesion of the eyelid to provide relief for an eroded or painful cornea.
3163	Excision of superficial lid tumour (for use by ophthalmologists only)	47.00	0005			
3165	Repair of skin laceration lid: Simple	27.30	0005	0010		
3167	Diathermy to wart on lid margin	12.00	0005	0010		
3168	Removal of embedded foreign body from eyelid	35.60	0005	0010		
3169	Electrolysis of any number of eyelashes: Per eye	15.00	0005	0010		
3171	Excision of Meibomian cyst. For use of sterile tray, add item 0202	20.40	0005	0010		• Code 0202: Setting of sterile tray not chargeable by surgeon if performed under general anaesthetic and/or performed in hospital theatre.

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3173	Epicanthal folds	128.70	0005			**More information on code:** • Canthoplasty (reconstruction of canthus) involves increasing the lid margin by cutting the medial or lateral canthus (juncture of upper and lower eyelid); • The surgeon rearranges the anterior tissues of the lids to prevent adherence. • It is recommended that the descriptor of 3173 be revised to follow that of its equivalent CPT code 67950: Canthoplasty (reconstruction of canthus).
3174	DISCONTINUED 2017: Item 3174 [Botulinus toxin injection for blepharospasm (+ item 0198 + item 0201 + item 0202)] has been discontinued. Refer to item 6005					See item 6005
6005	Botulinus toxin injections: For blepharospasm (+ item 0198 + item 0201 + item 0202)	25	0005	0010		
3175	DISCONTINUED 2017: Item 3175 [Botulinus toxin injection in extra-ocular muscles (+ item 0198 + item 0201+ item 0202)] has been discontinued. Refer to item 6008					See item 6008
6008	Botulinus toxin injections: In extra-ocular muscles (+ item 0198 + item 0201 + item 0202)	35	0005	0010		
3176	Lid operation for facial nerve paralysis including tarsorrhaphy but excluding cost of material	187.00	0005	0010		

- Entropion or ectropion

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3177	Entropion or ectropion by Cautery	10.00	0005	0010		
3179	Entropion or ectropion by Suture	49.40	0005			• *Item 3179 may not be used in conjunction with item 3181 or item 3183*
3181	Entropion or ectropion by Open operation	111.50	0005			• *Item 3181 may not be used in conjunction with item 3179 or item 3183*

3183	Entropion or ectropion by free skin, mucosal grafting or flap	122.60				• *Item 3183 may not be used in conjunction with item 3179 or item 3181*

- Reconstruction of eyelid

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3185	Staged procedure for partial or total loss of eyelid: First stage	259.00	0005			
3187	Staged procedure for partial or total loss of eyelid: Subsequent stage	206	0005			• Should be preceded by 3185 (performed at an earlier date)
3189	Full thickness eyelid laceration for tumour or injury: Direct repair	136.50	0005			
3172	Blepharoplasty lower eyelid plus fat pad	125.80	0005			**More information on code:** • Involves dissecting the skin of the lower eyelid to the subcutaneous/muscle fascial layers; • The skin is pulled tight and excess skin is excised; • Muscle fascia may be sutured to support sagging muscles; • Orbital fat, or an extensive herniated fat pad, is removed from the tissues.
3191	Blepharoplasty: Upper lid for improvement in function (unilateral)	150.20	0005			*• Modifier 0005 is applicable if a reconstruction was done on both eyelids* **More information on code:** • Blepharoplasty of the upper eyelid involves an incision, usually in the crease of the upper eyelid, with dissection of the skin of the upper eyelid to the subcutaneous/muscle fascial layers; • The skin is pulled tight and redundant skin is excised and muscle fascia may be sutured to support sagging muscles with removal of orbital fat, as well as excessive redundant skin that mechanically weighs down the eyelid, obstructing the visual field.

- Ptosis

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3193	Repair by superior rectus, levator or frontalis muscle operation	190.00	0005			**More information on code:** • Involves repair of blepharoptosis *(abnormal low-lying upper eyelid margin with the eye in primary gaze*) by frontalis muscle technique or fixation (using autologous fascia to create a sling) technique or levator complex isolation and advancement onto the tarsal plate.
3195	Ptosis: By lesser procedure e.g. sling operation**: Unilateral**	137.60	0005			
3197	Ptosis: By lesser procedure e.g. sling operation: **Bilateral**	166.00	0005			

Conjunctiva

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3199	Repair of conjunctiva by grafting	132.00	0005	0010		
3200	Repair of lacerated conjunctiva	47.00	0005	0010		

Eye: General

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3196	Diamond knife: Use of own diamond knife during intraocular surgery	12		0005		

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
+ 3190	Holmium laser apparatus (ophthalmic): Hire fee for one or both eyes done in one session	109.00		0005		
+ 3198	Excimer laser: Hire fee (per eye)	284.13		0005		*• Equipment hire, to be coded per eye* *• Appropriate for equipment hire, if the procedure is performed in the medical doctors' own facility with own/hired equipment* *• If the hospital/institution where the procedure is performed, codes for the Excimer laser equipment, the doctor may not use item 3198 merely for the fact that the procedure was performed with an Excimer laser*
+ 3201	Laser apparatus (ophthalmic): Hire fee for one or both eyes done in one session (Not to be used with IOL Master)	109		0005		*• Appropriate for laser equipment hire, one or both eyes, done in one session* *• For laser procedures other than eye procedures: Refer to item 5930: Surgical Laser apparatus: Own equipment hire* *• Own equipment hire for Candella laser apparatus (item 5932) must be negotiated with the relevant medical scheme*
+ 3202	Phako emulsification apparatus: Equipment Hire	109		0005		
+ 3203	Vitrectomy apparatus: Hire fee	120		0005		

Ultrasound

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDURE	NOTES
3631	Ophthalmic examination	50.00		0005 0010		*• Item 3631 may not be combined with item 3632*
3632	Axial length measurement and calculation of intra ocular lens power. Per eye. Not to be used with item 3034	50.00		0005 0010		*• Appropriate per eye prior to cataract extraction and lens insertion* *• Appropriate for axial measurement and calculation of intra-ocular lens power per eye* *• Item 3632 includes item 3034* *• Item 3632 may not be combined with item 3631*

6.3. Oncology related services in non-oncology facilities

CODE	DESCRIPTION	RVU	VALID MODIFIER	INVALID MODIFIER	ADD-ON FOR PRIMARY PROCEDUR	NOTES
5782	Isotope Therapy: Administration of low dose surface applicators, up to five applications. Typically, an out -patient procedure. The cost of materials is not included	77.81				• *Item 5782 is appropriate for use by ophthalmologists in treatment when applicable*