FEE BENCHMARKS ADVISORY COMMITTEE REPORT 2020

RECOMMENDATIONS FOR ANAESTHETIST FEE BENCHMARKS AND DOCTORS' INPATIENT ATTENDANCE FEE BENCHMARKS

Recommendations for Anaesthetist Fee Benchmarks and Doctors' Inpatient Attendance Fee Benchmarks

This report lays out the Fee Benchmarks Advisory Committee's[1] (referred to as Committee in this report) recommendations on reasonable fee benchmarks for (a) anaesthetist fees for common surgical procedures and (b) doctors' inpatient attendance fees for hospital admissions, in the private sector. It details the approach adopted to determine these benchmarks, the key feedback received from various stakeholders who were consulted, and the recommendations of the Committee.

Background

2 The first set of fee benchmarks on surgeon fees for common surgical procedures that was published in November 2018 provided a reference for different stakeholders to make more informed decisions. **In this second set of fee benchmarks, the Committee recommends complementary fee benchmarks for anaesthetist fees and doctors' inpatient attendance fees**.

3 The development of anaesthetist fee benchmarks was also in response to doctors' feedback provided during the 2018 fee benchmarks consultations. Many surgeons suggested that the Committee look into providing guidance for anaesthetist fees, given that anaesthesia support is an integral component of surgery. As it has been common practice to set anaesthesia fees as a proportion of surgeon fees, the College of Anaesthesiologists, Singapore (CAS) also suggested a fundamental review of such a fee structure to better reflect the effort required for managing anaesthetic risks in surgery.

4 The Committee has worked with the CAS and several public sector anaesthetist consultants to develop fee benchmarks that were independent of surgeon fees, taking into account the anaesthesia risks associated with the surgery and any added complexity arising from the patient's condition. The recommendation for the anaesthetist fee benchmarks is a culmination of many months of discussions and iterations with CAS and the selected anaesthetist consultants.

5 The Committee assessed that it would also be useful to provide fee benchmarks for doctors' inpatient attendance fees, which is generally charged by doctors for medical consultations and reviews provided during inpatient admissions.

[1] The composition of the Committee is in Annex A.

Anaesthetist fee benchmarks

Approach & methodology

6 Scope. The **anaesthetist fee benchmarks were developed for procedures that have a corresponding surgeon fee benchmark** to provide complete information on doctors' fees for surgeries commonly performed in the private sector. Nonetheless, the approach used could be considered for the development of anaesthetist fee benchmarks for more procedures in the future.

7 Anaesthetic risk index. The Committee considered several methods which it could base the anaesthetist fees on, including using a time-based system and Relative Value Guide (which is adopted for the Medicare Benefits Schedule used by the Australian government and Medical Association). However, using such systems could make financial counselling to patients, which is commonly undertaken by the surgeons on behalf of the anaesthetists, challenging. The Committee thus assessed these systems to be impractical for the local context and instead advised setting an anaesthetist fee range for each procedure based on the Table of Surgical Procedure (TOSP)[2], a system that is familiar to healthcare providers, and also used for the surgeon fee benchmarks.

8 As the TOSP is organised by surgical complexity alone and does not consider anaesthetic complexities, the Committee sought assistance from CAS to **determine the anaesthetic risk, effort, complexity and time taken for routine cases for each surgical procedure, using an index**. For example, if a procedure causes more bleeding, takes more time, needs special anaesthesia techniques, or requires the patient to be positioned in a way that increases the anaesthetic risk, it would be ranked higher on the index.

9 Using 2018 transacted anaesthetist fees as reference, the Committee determined a "base fee" for each index, which would form the lower bound of the fee range that would reflect the baseline anaesthetic risk and effort for each surgical procedure.

10 Patient variabilities affecting anaesthesia. Besides anaesthetic risks that are inherent for each procedure, anaesthetic support can also be complicated by a patient's physiological and medical condition. For example, comparing two different profiles of patients undergoing the same surgery, a person with pre-existing medical conditions or has airway problems would face higher anaesthetic risks compared to a person who is generally healthy. The fee benchmarks thus had to consider such patient-specific factors. Hence, **there is a fee range for each procedure, where the lower bound is generally associated with healthy patients / patients with lower anaesthetic risks, while the upper bound is generally for patients with multiple or poorly controlled medical conditions / patients with higher anaesthetic risks**.

[2] The TOSP provides a unique identifier and description for all surgical procedures which may be claimed from MediShield Life and MediSave. The Table classification number (from 1A to 7C) indicates how complex the surgery is, with a higher classification number generally indicating higher complexity. Both MediShield Life claim limits and MediSave withdrawal limits are pegged to this classification number.

11 As not all procedures see the same range of patients, different procedures have different fee ranges. A procedure that typically sees patients that range from the young to old, including the fit to the chronically ill, would have a wider fee range. Conversely, a procedure of similar anaesthetic risk but typically sees only fit and healthy patients (e.g. procedures common for sports injury) would have a narrower fee range. Besides the anaesthetic risk index, CAS also advised on the patient variability for each procedure.

12 Both the anaesthetic risk index and patient variability proposed by CAS were independently reviewed by selected anaesthetist consultants.

13 System impact and other considerations. The Committee also carefully considered the potential cost impact to the system. Given that the new benchmarks are not just a guideline for fees, but also a change in the way of charging for anaesthesia care, some fluctuations compared to historical fees would be expected and it would differ by procedure. **The Committee was mindful for the need to set fair and reasonable fees that were commensurate with the anaesthetist's risk and effort**. In determining the fee benchmarks, the Committee was also mindful to ensure that majority of the anaesthetists would not be significantly affected. In addition, it took into account potential inflation as the benchmarks would only be reviewed in a few years' time.

Doctors' inpatient attendance fee benchmarks

Approach & Methodology

14 Scope. Inpatient attendance fees refer to the doctors' professional consultation fees for a patient who is already hospitalised. The fees cover attendances by doctors in the General Ward, High Dependency Unit (HDU) and Intensive Care Unit (ICU). *Fee benchmarks for attendance fees for ICU cases in this report apply only to ICU cases requiring lower intensity of management and monitoring*. The Committee had considered fees for the full spectrum of ICU care. However, the model of care for medium to high intensity ICU cases differs in private hospitals – some could be cared for by multiple doctors of various specialties, each focusing on its area of expertise, while others could be cared for primarily by a doctor specifically trained in ICU care. The effort and time required of each doctor in the different models could vary significantly. Hence, it was challenging to set a meaningful fee range that could encompass the range of effort or work done. The Committee thus recommended fee ranges only for the lower intensity ICU cases, to serve as a baseline reference for stakeholders. The Committee will continue to study and work on the development of fee benchmarks for medium to high intensity ICU cases.

15 References. In considering an appropriate fee structure, the Committee took reference from the Singapore Medical Association (SMA) 2006 Guideline on Fees (GOF), inflation rates, samples of doctors' financial counselling forms, available 2019 data of hospital cases, as well as feedback from doctors during consultation sessions.

16 Fee range. Like the surgeon and anaesthetist fee benchmarks, doctors' inpatient attendance fee benchmarks are also a range, to cater for varying complexity, duration and frequency of consultations within a day. For example, higher fees could

be justified for complex cases which may require longer consultations and / or more frequent reviews within a day.

Stakeholder engagement and consultation

17 As part of the development process of the benchmarks, the Committee consulted various stakeholders on a preliminary set of fee benchmarks in order to ensure different perspectives were heard before refining and finalising its recommendations. Key stakeholders[3] consulted included:

a. Doctors – Anaesthetists, surgeons and physicians primarily from the private sector;
b. Council members of the professional bodies (Academy of Medicine Singapore, Singapore Medical Association and the College of Family Physicians Singapore) representing the wider medical community; and
c. Health insurers as well as Third-Party Administrators (TPAs).

18 The key points of the feedback received are summarised as follows:

a. Anaesthetist fee benchmarks. Overall, stakeholders were generally supportive of having anaesthetist fee benchmarks that were independent of surgeon fees. Anaesthetists asked for a base fee that was more commensurate with the risk, time and effort undertaken by them. Anaesthetists also highlighted that anaesthetic risks for Caesarean Sections were generally higher than many other common procedures but were not reflected in the current fees. The base fee and fees for Caesarean Sections have been adjusted in response to the anaesthetist community's feedback.

b. Doctors' inpatient attendance fee benchmarks. Overall, feedback for the initial set of doctors' inpatient attendance fee benchmarks was mixed. Some doctors agreed that the proposed benchmarks were fair and reflective of current charges for majority of cases; others felt the lower bound was too low, especially for specialties where patients tend to require longer consultations (e.g. psychiatric, neonates, transplant cases). Doctors also asked for clear guidance on additional charges for call-backs after-office hours. The fee benchmarks and its accompanying notes have been refined to address these concerns.

In addition, several doctors raised concerns that having fee benchmarks for only the lower intensity ICU cases could be incomplete. Payers or patients could mistake that as the cap for ICU cases requiring medium to high intensity of management and monitoring. They therefore suggested to make the guidelines clearer. Insurers also highlighted challenges in differentiating the severity of cases based on claims data. The Committee has made clearer that the doctors' inpatient attendance fee benchmarks for

[3] About 200 specialists from the College of Anaesthesiologists, Singapore, representatives from the professional bodies, public and private sector medical professionals, as well as insurers were consulted over ten sessions held in November and December 2020.

ICU cases are only for *lower intensity ICU cases*. This would serve as a baseline reference for stakeholders, while the Committee continues to study and develop benchmarks for medium to high intensity ICU cases.

c. Insurers' use of fee benchmarks. Doctors raised concern that insurers and TPAs might set their panel rates at the lower end or even below the fee benchmarks, given their experience with insurers' and TPAs' use of surgeon fee benchmarks. They called on insurers to respect the full range of the fee benchmarks in determining their panel fees.

Key recommendations

19 The Committee's recommended fee benchmarks for anaesthetist fees and doctors' inpatient attendance fees can be found in Annexes B and C respectively. General principles and notes accompany each set of benchmarks to guide users on how to interpret and use the fee ranges. Similar to the surgeon fee benchmarks, to ensure that the benchmarks are effective and helpful to all stakeholders, the Committee would like to recommend that stakeholders use the fee benchmarks in the following manner:

20 Doctors. Doctors should use the fee benchmarks to determine their charges and make reference to it when providing financial counselling to patients. If doctors charge above the benchmarks, they should inform and justify the higher fees to the patient and the insurer (where applicable) in advance, except when circumstances do not permit him to do so. At the end of the day, doctors should satisfy themselves that the fee charged in each case is fair, reasonable and appropriate for the services provided, with due consideration given to the unique circumstance of each case.

21 Patients. Patients are encouraged to use the benchmarks and published bill size information found on MOH's website as references to discuss care and treatment options with their doctors. They can also consider approaching their referring doctors or family doctors for advice. Patients should also bear in mind that fees could be affected by different factors including complexity of patient's condition and fees alone are not a direct measure of quality – higher fees do not necessarily mean quality care and vice versa.

22 Payers. Insurers and TPAs should use the benchmarks fairly and appropriately, and should refer to the benchmarks in determining reasonable charges during claims assessment. If there is a need to depart from the fee benchmarks, an explanation should be given and the justifications for doing so.

23 Government. MOH should ensure that benchmarks are kept updated, relevant, and the information readily accessible and understood by the public. Efforts to provide guidance on appropriate charging in other aspects of healthcare costs, e.g. hospital charges, and facility fee, should be considered. When the fee benchmarks become more comprehensive and established in the future, the government could consider requiring doctors to make reference to the fee benchmarks when advising patients on fees, for price transparency. All of these would go far in supporting stakeholders' use of the fee benchmarks, and in empowering patients to make informed decisions through meaningful conversations with providers on their care options. In addition, the

Committee recommends that MOH continues to review feedback provided during the consultation sessions by specialists on the description and categorisation of the procedures in the TOSP.

Acknowledgements

24 The Committee would like to specially thank the College of Anaesthesiologists, Singapore, Chapter of Intensivists and all the individual public sector doctors who have, in their personal capacity, taken the time to advise the Committee on the technical aspects in their respective specialties. The Committee would also like to thank the following organisations who have participated in the consultation session for their feedback and suggestions:

Professional Bodies

1. Academy of Medicine Singapore (AMS)
2. College of Anaesthesiologists, Singapore (CAS)
3. College of Family Physicians Singapore (CFPS)
4. Singapore Medical Association (SMA)
5. Singapore Medical Council (SMC)

Insurers and TPAs

6. Life Insurance Association (LIA)
7. All Integrated Shield Plan insurers, including AIA, Aviva, AXA, Great Eastern Life, NTUC Income, Prudential, Raffles Health Insurance
8. TPAs, including Alliance Healthcare Group, Fullerton Health, Adept Health, MHC

ANNEX A

Composition of the Fee Benchmarks Advisory Committee

Name	Designation
Dr Lim Yean Teng *[Chairman]*	Senior Consultant & Cardiologist in private practice
Prof Ang Chong Lye	Senior Advisor, SingHealth; Clinical Professor & Senior Consultant Ophthalmologist, Singapore National Eye Centre
Mr Benedict Cheong	Chief Executive Officer, Temasek Foundation International
Dr Ho Kok Sun	Council Member, Academy of Medicine Singapore; General Surgeon in private practice
Dr James Lam Kian Ming	Chief Executive Officer, Mount Alvernia Hospital
Mr Karthikeyan Krishnamurthy *[member from 2018-2019]*	Vice President, National Trades Union Congress (NTUC)
Dr Lim Hui Ling	Honorary Assistant Secretary, College of Family Physicians Singapore; Family Physician
Ms Ngiam Siew Ying	Deputy Secretary (Policy), Ministry of Health
Dr Phua Kai Hong	Adjunct Senior Research Fellow, Institute of Policy Studies, Lee Kuan Yew School of Public Policy, National University of Singapore
Mr Richard Wyber *[member in 2018]*	Chief Partnership Distribution Officer, AIA Singapore
Dr Alan Ong *[member from 2019-2020]*	Convenor, Health Insurance Subcommittee, Life Insurance Association; Medical Director, AIA Singapore
Dr Tan Boon Yeow	Chief Executive Officer, St Luke’s Hospital
Dr Toh Choon Lai	Council Member, Singapore Medical Association; Orthopaedic Surgeon in private practice
Mr Zainul Abidin Rasheed	Former Senior Minister of State (Foreign Affairs)

ANNEX B

Doctors' Fee Benchmarks for Surgeries

The recommended benchmarks for surgeon fee and anaesthetist fee for surgeries are based on the Table of Surgical Procedures (TOSP) and should be read in conjunction with the following points:

1. Reference but not fee cap - The benchmarks serve as a reference of reasonable fee ranges in the private sector, and are not a cap that has to be strictly adhered to. Charges that are higher than the benchmarks may not be unreasonable, particularly where a case is unusual in its context or complexity and require significantly more time or effort. Doctors can charge outside of the fee benchmarks, with valid justification. However, they should inform the patient and the insurer (where applicable) before the procedure is carried out, except when circumstances do not permit him / her to do so.

2. Typical cases - The benchmarks are meant to cover routine and typical cases. Each benchmark is a range of fees, to cater for some variation in patients' conditions, but they exclude patients whose conditions are of high complexity or who may be very ill.

3. Emergency and after-office hours services - Doctors are advised to explain to patients in advance, where possible, if their fees for cases requiring emergency and after-office hours would exceed the benchmarks.

   a. **Where a procedure is typically performed as an emergency** (e.g. appendicectomy), the fee range would apply for most office hours and after-office hours cases performed before midnight.

   b. **Where a procedure is commonly performed under elective circumstances (i.e. not an emergency)** (e.g. cholecystectomy), urgent cases performed after office hours may be above the fee benchmark range. Doctors may reasonably factor in the time of the procedure in such cases.

4. When more than one surgical procedure is carried out - The recommended benchmarks are for cases in which only a single procedure is performed on the patient on any one occasion. However, in some cases, it could be in patients' interest to perform more than one procedure in the same sitting. In general, if the combination of procedures results in savings in time and effort, e.g. surgery performed through the same incision, the fees should not be the sum of individual fees should the procedures be carried out on separate occasions. Nonetheless, where doctors assess that a "1+1" computation is fair, e.g. if performing the combination of procedures together in a sitting involves higher complexity, effort, risk and time than if done separately, they can do so with proper justification.

5. Goods and Services Tax (GST) - The benchmarks exclude GST.

Surgeon fee benchmarks

6. How to use the fee range – The lower end of the fees is generally associated with less complex cases, whereas the higher end of fees is associated with more complex ones.

7. Assistance at operations - In determining the individual benchmark, the Committee only looked at hospital admissions with a single TOSP code. If there was more than one surgeon fee, all the fees submitted by each individual surgeon would have been added up and taken into consideration when determining the fee benchmark range. It is possible that some surgeons might have included assistant fee under the field for surgeon fee. Hence, the recommended benchmarks refer to the total professional fees for the surgical procedure, including any necessary assistance. Prior to the procedure, doctors are advised to inform patients of any assistance required.

Anaesthetist fee benchmarks

8. Only for anaesthetist providing anaesthesia support – The use of the anaesthetist fee benchmarks is intended only for anaesthetists providing anaesthesia support for procedures. Specifically, they are not intended for other specialties providing procedural sedation; and/or in procedures where no anaesthetist is in attendance (except for normal vaginal deliveries, where the anaesthetist may leave after providing epidural).

9. Mode of anaesthesia – The fee benchmarks are **NOT** intended to influence clinical practice as to the choice of a particular mode of anaesthesia (general anaesthesia / regional anaesthesia / monitored anaesthesia care).

10. What the fee range covers – The fee range covers the single continuous episode of anaesthetic care in support of the surgical procedure, including :

    a. Pre-operative anaesthesia consultation immediately before the surgical procedure;
    b. Intra-operative anaesthetic management (i.e. at the time of operation); and
    c. Immediate post-operative care and monitoring of the patient in the recovery unit.

    The fee benchmarks exclude :

    d. Pre-operative consultations on the same or different day for the purpose of complete evaluation of patients who might be at increased risk of anaesthesia due to the presence of medical comorbidities or other reasons where a separate anaesthesia consultation is necessary; and
    e. Post-operative consultation after discharge from recovery unit.

11. How to use the fee range – The fee benchmarks take into account the risks, expertise and time associated with anaesthetic care for an expected range of patients for a procedure; where the:

a. **Lower bound**: Represents cases for a healthy patient; or where no anaesthetic problems are identified; or is ASA[4] 1 or equivalent. For certain procedures (e.g. Arteriovenous fistula creation, Coronary Artery Bypass Graft), where the baseline patient is not healthy (e.g. patient with progressive renal failure and ischaemic heart disease respectively), the lower bound would apply for patients with the baseline condition which required the procedure, and without other anaesthetic problems identified.

b. **Midpoint**: Represents cases whereby the patient has mild and controlled disease; or has presence of anaesthetic issues, e.g. anaesthetic problems such as severe post-operative nausea vomiting, physical abnormalities, difficult intravenous access, latex allergies; or is ASA 2 or equivalent.

c. **Upper bound**: Represents more complex cases where the patient has poorly controlled, severe or multiple medical conditions that significantly increase the risk and/or effort of anaesthetic care; or has serious anaesthetic issues, e.g. airway problems, anaphylaxis; or is ASA 2 with presence of other anaesthetic issues or multiple medical conditions; or is ASA 3 or equivalent.

If a case departs from the routine, e.g. the patient is an ASA 1, but due to unforeseen circumstances, the duration of the surgery is significantly longer than usual, **the anaesthetist has the discretion to vary the fees to reflect the added risk, effort and time required**.

[4] Refers to the American Society of Anesthesiologists (ASA) classification that assesses and communicates a patient's pre-anaethesia medical co-morbidities.

Surgeon & Anaesthetist Fee Benchmarks with Explanatory notes (by Table of Surgical Procedures) (As of 1 Feb 2021)

* Indicates that fee benchmarks have been updated.

SA – Integumentary (Skin and Breast)

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
1	SA865S	Skin, Keratoses/Warts/Tags/Similar Lesions, Excision (not more than 5 lesions)	1A	350	630	500	750
2	SA800S	Skin and Mucous Membrane, Various Lesions, Excision Biopsy	1A	350	800	680	1,100
3	SA852S	Skin and Subcutaneous Tissue, Tumor/Cyst/Ulcer/ Scar, Excision/Punch/Shave biopsy, Lesion size up to and including 15mm in diameter	1A	240	1,000	500	800
4	SA840S	Skin and Subcutaneous Tissue, Hematoma, Abscess/Cellulitis/Similar lesion<3cm, Saucerisation/Incision & Drainage	1A	230	1,050	590	950
5	SA853S	Skin and Subcutaneous Tissue, Wound, Debridement <3cm	1A	240	1,150	500	800
		Note: Higher end of surgeon fees may be associated with very contaminated/ dirty wounds or deep wounds requiring extensive debridement.					

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
6	SA710B	Breast, Various Lesions, Trucut Biopsy, ultrasound guided or stereotactic (single)	1B	780	1,200	545	700
		Note: Higher end of surgeon fees may be associated with lesions that are more complex to biopsy (e.g. small size in inaccessible location).					
7	SA854S	Skin and Subcutaneous Tissue, Wound (large>3cm), Secondary Suture	1B	750	1,550	545	850
		Note: Higher end of surgeon fees may be associated with wounds that require revision prior to secondary suture, to enable a tension free wound closure.					
8	SA843S	Skin and Subcutaneous Tissue, Laceration (superficial) of less than 7cm, Repair	1B	280	1,800	590	950
9	SA702S	Skin and Subcutaneous Tissue, Tumor/Cyst/Ulcer/Scar, Excision biopsy, Lesion size more than 15mm in diameter	1B	910	1,900	500	800
		Note: Higher end of surgeon fees may be associated with a location of higher morbidity such as the face or a joint flexure.					
10	SA841S	Skin and Subcutaneous Tissue, Hematoma /Carbuncle Cellulitis/Similar Lesion>3cm, Saucerisation/Incision with Drainage	1B	700	2,200	590	950
		Note: Higher end of surgeon fees may be associated with a location of higher morbidity such as the face or a joint flexure.					

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
11	SA709B	Breast, Various Lesions, Trucut Biopsy, ultrasound guided or stereotactic (multiple)	1C	910	2,250	680	900
		Note: Higher end of surgeon fees may be associated with lesions that are more complex to biopsy (e.g. small size in inaccessible location)					
12	SA839S	Skin and Subcutaneous Tissue, Arteriovenous malformation/Hemangioma/Lymphangioma <3cm excluding face, hands, genitalia, Excision	2A	1,350	2,350*	590	750
13	SA701S	Skin and Subcutaneous Tissue, Tumor/Cyst/Ulcer/Scar, Excision biopsy, removal of 2 or more or recurrent or complicated (adherent), excision	2A	800	2,800	500	800
		Note: Higher end of surgeon fees may be associated with a location of higher morbidity such as the face or a joint flexure.					
14	SA704B	Breast, Lumps, Imaging Guided Vacuum Assisted Biopsy, Single lesion	2B	1,650	2,700	545	700
		Note: Higher end of surgeon fees may be associated with more inaccessible locations.					
15	SA850S	Skin and Subcutaneous Tissue, Sinus (deep>3cm), Excision with/without biopsy	2B	1,800	3,000	680	1,100
16	SA715S	Soft Tissue (Lower Limb), Tumor/Tumor-like Lesions, Marginal Excision	2C	2,150	3,200	680	1,100

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
17	SA811S	Skin and Subcutaneous Tissue, Deep>3cm/Extensive Contaminated Wound, Debridement	2C	1,400	3,200	590	950
		Note: Higher end of surgeon fees may be associated with a location of higher morbidity such as the face or a joint flexure.					
18	SA812B	Breast, Lump (single), Excision biopsy	2C	2,500	3,200	680	900
		Note: Higher end of surgeon fees may be associated with procedures involving larger lesions.					
19	SA706B	Breast, Lumps, Imaging Guided Vacuum Assisted Biopsy, > 1 lesions	2C	2,300	4,150	590	750
		Note: Surgeon fees are typically higher when more biopsies are performed. Higher end of surgeon fees may be associated with 4 or more lesions, whereas the lower end of fee range may be associated with 2 lesions or less.					
20	SA712B	Breast, Various Lesions, wire localisation, excision (single)	3A	2,500	4,000	770	1,000
		Note: Higher end of surgeon fees may be associated with recurrent surgery, locations that are harder to access and defects that require mobilization of breast tissue for a more cosmetically acceptable appearance					
21	SA838S	Skin and Subcutaneous Tissue, Arteriovenous malformation/Hemangioma/Lymphangioma >3cm excluding face, hands, genitalia, Excision	3A	2,350*	4,500*	680	1,100

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
22	SA813B	Breast, Lumps (multiple/bilateral), Excision biopsy Note: Higher end of surgeon fees may be associated with more difficult locations, procedures involving larger lesions and/or greater number of lesions.	3A	3,200	5,350	770	1,000
23	SA803S	Skin and Subcutaneous tissue(ear/nose/eyelid/face) complex lacerations, repair	3B	3,200	5,000	590	950
24	SA842S	Skin and Subcutaneous tissue, Lacerations (deep >3cm/multiple) lacerations, repair/toilet & suture, with/without debridement	3B	3,200	5,000	770	1,250
25	SA711B	Breast, Various Lesions, wire localisation, excision (multiple) Note: Higher end of surgeon fees may be associated with recurrent surgery, more lesions, locations that are harder to access and defects that require mobilization of breast tissue for a more cosmetically acceptable appearance	3B	3,650	5,600	995	1,300
26	SA822B	Breast, Tumor (malignant), Wide Excision/ Lumpectomy/Segmental Mastectomy/ Partial Mastectomy Note: Higher end of surgeon fees may be with lesions in locations that are harder to access, and defects that require mobilization of breast tissue for a more cosmetically acceptable appearance	3C	3,200	5,450	995	1,300
27	SA716S	Soft Tissue (Lower Limb), Tumors (benign), Wide Excision Biopsy	4A	3,200	5,350	950	1,500

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
28	SA721S	Soft Tissue (Upper Limb), Tumors (benign), Major Excision Biopsy	4A	3,250	5,350	950	1,500
29	SA837S	Skin and Subcutaneous Tissue, Arteriovenous malformation/Hemangioma/Lymphangioma on face, hands, genitalia, Excision	4A	3,600	6,000	995	1,600
30	SA826B	Breast, Tumor (malignant), Simple Mastectomy	4A	4,050	7,000	950	1,250
		Note: Higher end of surgeon fees may be associated with larger tumours with chest wall invasion or extensive skin invasion.					
31	SA705B	Breast, Lump (removal) with parenchymal flap closure (unilateral/bilateral)	4A	4,300	8,050	1,040	1,500
		Note: Higher end of surgeon fees may be associated with recurrent surgery, locations that are harder to access and larger, odd-shaped defects that require greater expertise for flap closure.					
32	SA707B	Breast, Tumor (malignant), Wide Excision/ Lumpectomy/Segmental Mastectomy/ Partial Mastectomy, with Sentinel Node Biopsy/ Axiliary Node Sampling	4A	5,350	9,200	1,220	1,600
		Note: Higher end of surgeon fees may be associated with lesions in locations that are harder to access, and defects that require mobilization of breast tissue for a more cosmetically acceptable appearance. Higher surgeon fees can also be associated with more sentinel nodes or challenging locations.					

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
33	SA823B	Breast, Tumor (malignant), Wide Excision/ Lumpectomy/Segmental Mastectomy/ Partial Mastectomy, with Axiliary Clearance, with/without Sentinel Node Biopsy	4B	5,150	9,000	1,220	1,600
		Note: Higher end of surgeon fees may be associated with lesions in locations that are harder to access, and defects that require mobilization of breast tissue for a more cosmetically acceptable appearance. Higher surgeon fees can also be associated with involved enlarged axillary lymph nodes with surrounding tissue invasion.					
34	SA833B	Breast, Tumor (malignant), Nipple / Skin sparing Mastectomy	4C	5,250*	9,500*	950*	1,250*
35	SA827B	Breast, Tumor (malignant), Simple Mastectomy with Sentinel Node Biopsy/ Axiliary Node Sampling	4C	5,250	9,500	1,445	1,900
		Note: Higher end of surgeon fees may be associated with larger volume of breast tissue and larger tumors with surrounding invasion. Higher surgeon fees may be associated with more sentinel nodes/more challenging locations of nodes.					
36	SA834B	Breast, Tumor (malignant), Nipple / Skin sparing Mastectomy with Sentinel Node Biopsy/ Axiliary Node Sampling	5A	5,450*	10,700*	1,445*	1,900*
37	SA824B	Breast, Tumor (malignant), Simple Mastectomy with Axiliary Clearance, with/without Sentinel Node Biopsy	5A	5,450	10,700	1,670	2,150
		Note: Higher end of surgeon fees may be associated with larger volume of breast tissue and larger tumors with surrounding invasion.					

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
38	SA836S	Skin and Subcutaneous Tissue, Arteiovenous malformation/Hemangioma/Lymphangioma (large and deep-seated), Excision	5C	6,400	7,750	1,445	2,100

SB – Musculoskeletal

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
1	SB745J	Joint, Various Lesions, Joint aspiration/arthrocentesis/injection	1A	300	1,600	500	800
		Note: Higher end of surgeon fees may be associated with deeper joints (e.g. hips) while the lower end of fee range is associated with superficial joints (e.g. knees).					
2	SB803N	Nail, Infection/Injury, Avulsion	1A	500	1,600	500	800
		Note: Higher end of surgeon fees may be associated with more than one nail avulsion performed, greater trauma of the distal phalanx or where the avulsion is associated with a large extent of excision.					
3	SB802U	Upper Limb, Fracture/Dislocation, Manipulation and Reduction	1B	1,050	2,150	500	800
4	SB826B	Bone and Joints (Upper Limb), Removal of Simple Implants (e.g. Rush Rods/Wires/K-Wires/Pins/Screws)	1C	1,000	2,400	545	850
		Note: Higher end of surgeon fees may be associated with a greater number of or deeper-set implants					
5	SB809B	Bone and Joints (Lower Limb), Removal of Simple Implants (e.g. Rush Rods/Wires/K-Wires/Pins/Screws)	1C	1,250	2,700	545	850
		Note: Higher end of surgeon fees may be associated with a greater number of or deeper-set implants					
6	SB709H	Hand, Flexor Tendon, Trigger Finger (single), Release	2A	1,250	2,400	500	750

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
7	SB808B	Bone and Joints (Lower Limb), Plates and Screws/Nails, Removal	2B	1,800*	3,850	680	1,100
8	SB825B	Bone and Joints (Upper Limb), Plates and Screws, Removal	2B	1,800*	3,850	680	1,100
9	SB805T	Tendon Sheath (Upper Limb), De Quervain's (unilateral), Release	3A	2,050	3,650	545	800
10	SB708H	Hand, Flexor Tendon, Trigger Finger (multiple), Release Note: Higher end of surgeon fees may be associated with more finger releases.	3A	1,700	3,850	680	1,000
11	SB722F	Foot, Fractures, Simple, single	3A	4,000	5,350	995	1,600
12	SB809T	Tendon-Achilles (Lower Limb), Disruption, Repair	3A	5,150	7,200	1,040	1,350
13	SB801A	Ankle, ankle fracture, unimalleolar, ORIF	3B	6,000	7,500	1,220	1,600
14	SB800P	Patella, Fracture, Open Reduction and Internal Fixation	3B	6,000	8,550	995	1,300
15	SB804H	Hand, Crush Injuries (complex), Wound Debridement	3C	2,750	4,000	680	1,000
16	SB704H	Hand, Closed fracture, ORIF/plate and screws (single), joint/non-joint	3C	4,300	7,200	950	1,400
17	SB740S	Spine - Vertebroplasty or kyphoplasty (single level) Note: Higher end of surgeon fees may be associated with more complex cases.	4A	5,000	6,400	1,130	1,800

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
18	SB808K	Knee, Various Lesions, Meniscectomy with/without Arthroscopy	4A	4,800	6,950	1,220	1,600
19	SB700H	Hip/Knee therapeutic arthroscopy with/without synovectomy/ labral repair /FAI resection for hip Note: Benchmarks are for procedures for knee arthroscopy.	4A	5,700	7,500	1,130	1,650
20	SB700A	Ankle, ankle fracture, Bimalleolar, ORIF	4A	6,550	8,550	1,355	1,750
21	SB701C	Clavicle, Clavicle Fracture, Comminuted Plating With or without Bone Grafting	4A	5,350	8,550	1,445	1,900
22	SB705A	Ankle, Therapeutic arthroscopy	4A	4,800	8,550	1,130	1,450
23	SB819H	Hand, Tumors, Excision with Dissection of Neurovascular Bundle	4B	3,350	4,800	950	1,400
24	SB801R	Radius and Ulna, Fracture/Dislocation, Open Reduction and internal fixation with or without bone grafting	4B	6,300	8,550	1,220	1,600
25	SB706W	Wrist, Distal radius fracture, Open Reduction and Internal Fixation (ORIF) (complex, with autologous bone graft)	4C	6,400	9,800	1,445	2,100
26	SB715K	Knee, Meniscus/Cartilage, MIS meniscal repair	5A	6,400	9,350	1,130	1,450
27	SB707S	Shoulder, Shoulder soft tissue injury, MIS/open Bankart or Superior Labrum from anterior to posterior (SLAP) repair	5A	6,650	10,700	1,580	2,050
28	SB709S	Shoulder, Shoulder soft tissue injury, MIS/open decompression alone	5A	6,650	10,700	1,580	2,050

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
29	SB708S	Shoulder, Shoulder soft tissue injury, MIS/Open Bankart repair with Superior Labrum from anterior to posterior (SLAP) repair/rotator cuff repair	5B	8,550	10,700	1,670	2,150
30	SB710S	Shoulder, Shoulder soft tissue injury, MIS/open decompression with cuff repair	5B	9,650	12,050	1,670	2,150
31	SB838H	Hip, Various Lesions, Hemi-Arthroplasty	5C	6,400	9,100	1,895	3,050
32	SB801B	Bone (Lower Limb), Deformities, Corrective Surgery with Internal Fixation with or w/o Fluoroscopy	5C	7,500	9,400	1,670	2,150
33	SB700K	Knee, Arthroscopy, knee ligament reconstruction (1 or more)	5C	6,700	10,150	1,400	1,800
34	SB819B	Bone and Joints (Upper Limb), Deformities, Osteotomies and Fixation with or without Fluoroscopy/Bone graft	5C	6,000*	10,150	1,580	2,050
35	SB701K	Knee, Ligaments/Meniscus/Cartilage/Bone combined, MIS ACL or PCL reconstruction	5C	7,500	10,700	1,400	1,800
36	SB704K	Knee, Ligaments/Meniscus/Cartilage/Bone combined, MIS ligament reconstruction with meniscectomy	5C	8,550	10,700	1,400	1,800
37	SB712K	Knee, Meniscus/Cartilage (small defects), MIS/open Mosaicplasty or OATS	5C	6,950	10,700	1,400	1,800
38	SB800K	Knee Ligaments, Disruption, Reconstruction and Repair	5C	8,050	10,700	1,400	1,800
39	SB703K	Knee, Ligaments/Meniscus/Cartilage/Bone combined, MIS ligament reconstruction with meniscal repair	5C	8,400	11,500	1,400	1,800

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
40	SB711S	Shoulder, Shoulder soft tissue injury, MIS/open decompression with cuff repair & excision of distal clavicle	5C	8,550	12,300	1,760	2,300
41	SB810K	Knee, Various Lesions, Primary Total Joint Replacement (Unilateral), open/MIS/navigated	6A	8,250	10,700	1,670	2,400
42	SB839H	Hip, Various Lesions, Primary Total Joint Replacement, open/MIS/navigated	6A	8,550	12,850	1,895	3,050
43	SB803C	Cervical Spine, Various Lesions - Anterior decompression and fusion or disc replacement (1 segment)	6A	11,900	16,050	2,570	3,350
44	SB716K	Knee, Various Lesions, Primary Total Joint Replacement (Unilateral) with augmentation, requiring extra implants or bone grafts, open/MIS/navigated	6B	8,550	12,000	1,670	2,400
45	SB809K	Knee, Various Lesions, Total Joint Replacement (Bilateral)	7B	11,750	17,100	2,570	3,750

SC – Respiratory

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
1	SC703B	Bronchus/Lung, Bronchoscopy with/without biopsy	1B	1,050	1,600	590	950
2	SC704B	Bronchus/Lung, Bronchoscopy with biopsy, bronchoalveolar lavage	2A	1,050	2,000	770	1,250

SD – Cardiovascular

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
1	SD707B	Blood Vessels, Subcutaneous Implanted Vascular Port, removal Note: Higher end of surgeon fees may be associated with more difficult portacath removals e.g. when catheter is fractured or has displaced, with need for surgical exploration to identify and remove entire length of catheter.	1B	400	1,450	500	800
2	SD722V	Vein, Various Lesions, Imaging Guided Peripheral Insertion of Central Catheter (PICC)	1C	640	1,000	500	800
3	SD721V	Vein, Various Lesions, Imaging guided Insertion of Tunnelled Central Venous Catheter Note: Higher end of surgeon fees may be associated with recurrent cases or altered anatomy	2A	850	1,400	500	800
4	SD723V	Vein, Various Lesions, Imaging Guided Venous Port Insertion Note: Higher end of surgeon fees may be associated with altered anatomy, small vein, redo cases	2C	850	1,800	500	800
5	SD706B	Blood Vessels, Subcutaneous Implanted Vascular Port, Insertion Note: This procedure involves open surgical insertion via venous cutdown.	2C	1,200	2,700	680	1,100
6	SD811H	Heart, Coronary angiography	3A	2,150	3,200	770	1,250

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
7	SD713V	Vein, Varicose Veins, Imaging Guided Endovenous Laser Treatment, 1 leg Note: Higher end of surgeon fees may be associated with larger veins, length of vein to be treated, or procedure including ablation of small saphenous vein (SSV).	3B	4,350	6,500	860	1,250
8	SD821A	Artery, Various Lesions, Arterio-venuous Fistula Creation	3C	1,700	3,500*	1,310	2,100
9	SD809H	Heart, Coronary Artery Disease, Cardiac Catherisation and Coronary Angiogram	3C	3,000	4,350	770	1,250
10	SD707H	Heart, Cardiac Catheterisation (left) and Intracoronary Physiological Assessment (inclusive of pressure wire) without Percutaneous Transluminal Coronary Angioplasty (PTCA)	3C	4,300	5,350	1,040	1,650
11	SD840A	Artery, Various Lesions, Arterio-venuous Fistula, Correction at original site	4A	3,500*	4,000*	1,310*	2,100*
12	SD810H	Heart, Coronary Disease, Coronary Angioplasty (transluminal), with/without angiocardiography Note: This code is for simple one-vessel coronary angioplasty. Excludes angioplasty for multiple vessels, which should be coded under SD713H.	4A	6,000	9,000	1,220	1,950

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
13	SD802H	Heart, percutaneous ablation of arrhythmia circuit or focus or isolation procedure involving 1 atrial chamber	4A	4,000	12,000	1,670	2,650
		Note: Lower end of surgeon fees may be associated with Simple Radiofrequency Catheter Ablation (e,g. SVT) with or without Electrophysiology Study; and higher end of surgeon fees may be associated with Complex Radiofrequency Catheter Ablation (with 3D mapping) with or without Electrophysiology Study.					
14	SD712H	Heart, Percutaneous Transluminal Coronary Angioplasty (PTCA) + stenting (1 vessel) - Complex (e.g. retrograde CTO intervention, complex bifurcation/trifurcation, IABP, Impella, LVAD), with/without IVUS/FFR or other physiological studies	4B	8,000*	12,200	1,130	1,800
		Note: Higher end of surgeon fees may be associated with complex interventions which include: - Complex Chronic Total Occlusion e.g. retrograde CTO intervention - Complex bifurcation/ trifurcation; or - Cases requiring haemodynamic support (e.g. IABP, Impella or LVAD)					
15	SD714H	Heart, Primary Percutaneous Transluminal Coronary Angioplasty for ST-elevation Myocardial Infarction	4B	9,650	12,850	2,345	3,750

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
16	SD713H	Heart, Percutaneous Transluminal Coronary Angioplasty (PTCA) + stenting (more than 1 vessel), with/without IVUS/FFR or other physiological studies	4B	9,000	13,900	1,670	2,650
		Note: This code is for multivessel stenting, with or without invasive intracoronary imaging or physiologic guidance.					
17	SD742H	Heart, Coronary Disease, Coronary Artery Bypass Graft (Open/MIS/off pump)	6C	16,050*	25,000*	3,470*	5,050*
		Note: Higher end of surgeon fees may be associated with high risk surgeries, and/or repeat heart bypass surgeries, including: (1) cases with operative risks that are Logistic Euroscore 6 and above, and/or (2) re-do Coronary Artery Bypass Graft with failed grafts, and/ or (3) cases requiring haemodynamic support (e.g. IABP, Impella or LVAD).					

SE – Hemic & Lymphatic

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
1	SE703L	Lymph Node (cervical) - Superficial, Various Lesions, Biopsy	1B	1,300*	2,300*	770*	1,250*
2	SE702L	Lymph Node (cervical) - Deep, Various Lesions, Biopsy	2C	2,000*	3,750*	770*	1,250*

SF – Digestive

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
1	SF804T	Tongue, Tongue Tie, Release	1A	280	850	590	950
2	SF701I	Intestine/Stomach, Upper GI endoscopy with / without biopsy Note: Higher end of surgeon fees may be associated with altered anatomy, more biopsies or biopsies of lesions in challenging locations.	1B	600	1,000	500	750
3	SF710C	Colon, Sigmoid, Sigmoidoscopy (flexible), Fibreoptic with/without biopsy	1B	600	1,000	500	750
4	SF841A	Anus, Perineal Abscess, Saucerisation/Drainage Note: Lower end of surgeon fees may be associated with straight forward incision, saucerisation and drainage. Higher end of surgeon fees may be associated with deep seated abscesses requiring more complex techniques of drainage and/or requiring a drain or seton. Ischorectal abscess drainages should be coded under: SF840A Anus, Ischiorectal Abscess, Saucerisation.	1B	1,250	2,950	635	1,000
5	SF833A	Anus, Fistula-in-ano, Excision/ Fistulectomy Note: Higher end of surgeon fees may be associated with recurrent surgery, more complex fistulae	2B	2,000	3,200	635	900
6	SF700I	Intestine/Stomach, Upper GI endoscopy with polypectomy/ removal of foreign body/diathermy of bleeding lesions / injection of varices / removal of single polyp	2C	1,000	1,600	500	750

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
7	SF702C	Colon, Colonoscopy, fibreoptic with/without biopsy	2C	1,100	1,600	500	750
8	SF703C	Colon, Colonoscopy (screening), fibreoptic with/without biopsy	2C	1,100	1,600	500	750
9	SF836A	Anus, Hemorrhoids, Hemorrhoidectomy with or without sigmoidoscopy Note: Higher end of fees may be associated with sigmoidoscopy or more difficult haemorrhoidectomy e.g. for prolapsed haemorrhoids.	2C	2,650	3,400	635	900
10	SF813E	Esophagus/Intestine/Stomach, Upper GI endoscopy with complicated polypectomy or Endoscopic Mucosal Resection	3A	1,100*	1,700*	590*	850*
11	SF704C	Colon, Colonoscopy, fibreoptic with removal of polyp (single or multiple less than 1cm) Note: Higher end of surgeon fees may be associated with polyps in challenging locations, more polyps or additional measures to achieve hemostasis.	3A	1,500	2,150	500	750
12	SF706C	Colon, Colonoscopy (screening), fibreoptic with removal of polyp (single or multiple less than 1cm) Note: Higher end of surgeon fees may be associated with polyps in challenging locations, more polyps or additional measures to achieve hemostasis	3A	1,500	2,150	500	750
13	SF818A	Abdominal Wall, Inguinal Hernia (infants & children), Herniotomy (Unilateral)	3A	1,950	2,350	860	1,250

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
14	SF837A	Anus, Hemorrhoids,Stapled haemorrhoidectomy	3A	3,000	3,750	635	900
15	SF814A	Abdominal Wall, Epigastric/Umbilical Hernia, Repair (MIS/open)	3A	2,650	4,350	1,040	1,650
		Note: Higher surgeon fees may be associated with larger defects and mesh placement. (Recurrent surgery should be coded under SF823A.)					
16	SF705C	Colon, Colonoscopy, fibreoptic with removal of polyps (multiple more than 1cm)	3B	1,700	2,550	500	750
		Note: Higher end of surgeon fees may be associated with polyps in challenging locations, larger polyps, more polyps or additional measures to achieve hemostasis					
17	SF819A	Abdominal Wall, Inguinal/Femoral Hernia, Unilateral Herniorrhaphy (MIS/open)	3B	3,200	5,350	1,040	1,500
		Note: Higher end of surgeon fees may be associated with larger hernia sacs, femoral hernias, hernias with complications and emergency surgery. Recurrent surgery should be coded under SF823A.					

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
18	SF849A	Appendix, Various Lesions, Appendicectomy Without Drainage, MIS/open	3B	4,200	6,700	1,130	1,800
		Note: Higher end of surgeon fees may be associated with challenging locations e.g. retrocecal appendix, adhesions from previous surgery, additional measures to secure the base and perforation. (Recurrent hernia should be coded under SF823A.)					
19	SF832A	Anus, Fistula-in-ano (high), complex and recurrent fistulectomy	3C	3,100	4,300	770	1,250
		Note: Higher end of surgeon fees may be associated with extensive perianal sepsis associated with the fistula.					
20	SF710B	Endoscopic Retrograde Cholangiopancreatography (ERCP) with sphincterotomy /removal of stone/ insertion of biliary stent	3C	3,200*	4,350*	950*	1,500*
		Note: Higher end of surgeon fees may be associated with more complex cases, e.g. altered anatomy, larger, harder stones, more stones, difficult bile duct cannulation etc.					
21	SF822A	Abdominal Wall, Strangulated/Obstructed Hernia, Repair without Bowel Resection	3C	3,950	7,500	1,220	1,950
		Note: Higher end of surgeon fees may be associated with emergency surgery, previous surgery and adhesions and larger defects					

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
22	SF817A	Abdominal Wall, Inguinal Hernia (infants & children), Herniotomy (Bilateral)	4A	3,000	4,500	1,040	1,500
23	SF801G	Gallbladder, Various Lesions, Cholecystectomy (open or lap)	4A	5,350	7,500	1,220	1,950
		Note: Complicated surgery should be coded under SF706G.					
24	SF723A	Appendix, Various Lesions/Abscess, Appendicectomy with Drainage (MIS/open)	4A	5,250	8,000	1,310	2,100
25	SF823A	Abdominal Wall, Ventral/Incisional/Recurrent Hernia, Repair (MIS/open)	4A	4,400	8,000	1,040	1,650
		Note: Higher end of surgeon fees may be associated with ventral/incisional hernia repair with complex abdominal wall reconstruction using component separation technique or mobilisation of myofascial flaps or recurrent hernia repair. Lower end of surgeon fee range is associated with Ventral/incisional hernia repair of abdominal wall, with primary closure of fascial defect or mesh repair (laparoscopic/open)					
26	SF820A	Abdominal Wall, Inguinal/Femoral Hernia, Bilateral Herniorrhaphy (MIS/open)	4C	5,000	8,000	1,310	1,900
		Note: Higher end of surgeon fees may be associated with recurrent surgery, larger hernia sacs, femoral hernias, hernias with complications or emergency surgery.					

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
27	SF706G	Gallbladder (acute/complicated) open or laparascopic cholecyestectomy	4C	5,550	8,600	1,310	2,100
		Note: Higher end of surgeon fees may be associated with recurrent surgery, adhesions, altered anatomy, previous inflammation of the gallbladder and biliary tree or for impacted stone.					
28	SF705G	Gallbladder, Various lesions, MIS/open cholecystectomy and transcystic common bile duct exploration	5A	6,500	10,000	1,490	2,400
		Note: Higher end of surgeon fees may be associated with recurrent surgery, adhesions, altered anatomy, previous inflammation of the gallbladder and biliary tree or for impacted stone. Higher end of surgeon fees may also be associated with more complex CBDE.					
29	SF814P	Parotid, Tumor, Superficial Parotidectomy	5C	9,300	12,650	2,345	3,050
30	SF803C	Colon, Various Lesions, Right/Left Hemicolectomy (MIS/open)	5C	10,100	14,450	2,210	3,200
		Note: Higher end of surgeon fees may be associated with recurrent surgery, adhesions or more complex cases such as larger tumors with invasion into surrounding structures.					
31	SF714P	Parotid, Total Parotidectomy, with/without preservation of facial nerve	6A	12,850	17,500	2,840	3,700

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
32	SF701C	Colon, Anterior Resection (OpenMIS)	6C	10,700	16,050	2,480	3,600
		Note: Higher end of surgeon fees may be associated with more complicated and difficult resections, particularly for low anterior resection.					
33	SF703R	Rectum, Ultra-low Anterior Resection (Total Mesorectal Excision) With/Without PLND	6C	14,450	20,700	3,020	4,400
		Note: Higher end of surgeon fees may be associated with recurrent surgery or more complex cases such as those involving lymphadenectomy.					

SG – Urinary

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
1	SG713B	Bladder, Cystoscopy, with or without biopsy	1B	700	1,150	500	750
2	SG718B	Bladder/Urethra, Cystoscopy, with urethral dilatation	1C	800	1,350	500	750
3	SG709B	Bladder, Cystoscopy, removal of foreign body/ureteric stent	1C	910	1,500	500	750
4	SG714B	Bladder/Urethra, Transurethral Resection of Bladder Tumour (<3cm)	4A	3,750	4,300	950	1,400
5	SG701U	Ureter, Extra Corporeal Shockwave Lithotripsy (ESWL) for ureteric stone	4A	3,200	4,700	770	1,000
6	SG800U	Ureter, Calculus, Ureteroscopy and lithotripsy with/without ultrasound	4A	4,000	4,750	770	1,100
7	SG802K	Kidney, Calculus, Extra Corporeal Shockwave Lithotripsy (ESWL)	4B	3,650	5,150	770	1,100

SH – Male Genital

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
1	SH808P	Penis, Paraphimosis/ Phimosis/ Reduction Prepuce, Circumcision Note: Surgeon fee range for infants aged ≤ 6 months.	1B	350	700	500	800
2	SH808P	Penis, Paraphimosis/ Phimosis/ Reduction Prepuce, Circumcision Note: Surgeon fee range for patients aged > 6 months.	1B	950	2,150	500	800
3	SH834P	Prostate Gland, Various Lesions, Trans-Rectal Ultrasound (TRUS) guided biopsy	1B	1,050	1,500	500	750
4	SH835P	Prostate Gland, Various Lesions, Saturation Prostate Biopsy	2A	1,950	3,200	500	750
5	SH802V	Vas Deferens, Various Lesions, Varicocelectomy (Microsurgical)	3C	4,300	5,900	860	1,100
6	SH836P	Prostate Gland, Various Lesions, Transurethral Resection of Prostate (TURP) (less than 30 gm)	4B	4,500	6,400	1,130	1,650
7	SH837P	Prostate Gland, Various Lesions, Transurethral Resection of Prostate (TURP) (more than 30 gm)	5C	5,350	7,500	1,400	2,050
8	SH830P	Prostate Gland, Various Lesions, Radical Prostatectomy (MIS/open)	6A	16,300	20,350	3,020	4,400

SI – Female Genital

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
1	SI806C	Cervix, Polyp, Excision/Erosion (simple) with Biopsy Note: Higher end of surgeon fees may be associated with more polyps being excised.	1B	300	820	500	750
2	SI820V	Vulva, Abscess, Incision Note: Higher end of surgeon fees may be associated with a larger or deeper abscess.	1B	850	1,950	500	750
3	SI823V	Vulva, Bartholin Cyst, Incision/Marsupialization with or without use of Laser Note: Higher end of surgeon fees may be associated with a larger or deeper cyst or with the use of a laser.	1B	850	1,950	500	750
4	SI810C	Cervix, Various Lesions, Colposcopy and Biopsy	1C	450	820	500	750
5	SI818U	Uterus, Genetic Abnormality/Fetal Maturity, with/without Ultrasound Guided Amniocentesis	1C	480	950	500	800
6	SI817U	Uterus, Genetic Abnormality, Ultrasound Guided Chorionic Biopsy	1C	860	1,050	500	800
7	SI820U	Uterus, Gravid, Evacuation (simple)	2A	700	1,550	500	750
8	SI843U	Uterus, Various Lesions, Curettage with/without Dilatation	2A	1,050	1,800	500	750

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
9	SI707C	Cervix, Various Lesions, Colposcopy, ablational and/or excisional treatment (eg. Laser Vapourisation/Loop Electrosurgical Excision Procedure/Laser Excision of Transformation Zone with Biopsy	2A	1,250	2,700	500	800
		Note: Higher end of surgeon fees may be associated with laser surgery and could be more extensive.					
10	SI819U	Uterus, Gravid, Evacuation (complicated)	2B	1,300	2,150	590	850
11	SI805C	Cervix, Polyp, Excision/Erosion (complicated) includes D&C with Biopsy	2B	1,500	2,450	500	750
12	SI725U	Uterus/cervix, Hysteroscopy, Diagnostic, D&C	2B	1,800	3,150	500	800
13	SI836U	Uterus, Pregnancy, Vaginal Delivery (with or without episiotomy repair)	2B	2,050	3,400	700	900
		Note: Anaesthetist fee benchmarks are for epidural administration only.					
14	SI704C	Cervix, Transcervical resection (TCR) Polyp (<2cm), hysteroscopic	2B	2,550	3,750	680	1,000
15	SI842U	Uterus, Various Lesions, Curettage with Colposcopy/Biopsy/Diathermy/ Cryosurgery/Laser Therapy of Cervix	2C	1,250	2,300	500	750
16	SI705C	Cervix, Transcervical resection (TCR) Polyp (>2cm), hysteroscopic	2C	2,700	4,000	680	1,000

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
17	SI833U	Uterus, Pregnancy, Complicated Vaginal Delivery (e.g. twins, breech, instrumental delivery)	3A	2,450	4,050	700	900
		Note: Anaesthetist fee benchmarks are for epidural administration only.					
18	SI803C	Cervix, Cervical Intraepithelial Neoplasia, Cone Biopsy with/without laser	3A	2,500	4,350	500	750
19	SI803O	Ovary, Tumor/Cyst, Cystectomy (simple, <5cm)	3B	4,500*	7,300*	1,220*	1,600*
20	SI700L	Laparoscopy, Therapeutic, except for Retrieval and Placement of Gametes and Placement of Embryos	3C	4,800	7,750	950	1,400
21	SI834U	Uterus, Pregnancy, Uncomplicated Caesarean Section	4A	3,400	4,800	1,130	1,800
22	SI802O	Ovary, Tumor/Cyst, Cystectomy (complicated, >5cm)	4A	6,400	9,000*	1,355	1,750
23	SI806O	Ovary, Tumor/Cyst, Oophorectomy/Salpingo-Oophorectomy (complicated)	4A	6,350	9,100	1,220	1,600
24	SI832U	Uterus, Pregnancy and Multiparity, Uncomplicated Caesarean Section and Tubal Ligation	4B	4,000	5,700	1,130	1,800
25	SI844U	Uterus, Pregnancy, Complicated Caesarean Section (see footnote for definition of 'complicated')	4B	4,600*	5,800*	1,310*	2,100*

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
26	SI713U	Uterus, Sub-total/Total Hysterectomy (<12 weeks), with/without Salpingo-Oophorectomy	4B	6,400*	9,050*	1,490*	2,150*
		Note: Surgeon fee benchmarks are not applicable to subtotal hysterectomy, which is usually not clinically recommended. If conducted, the fees for subtotal hysterectomy should generally not be higher than that for total hysterectomy.					
27	SI845U	Uterus, Pregnancy and Multiparity, Complicated Caesarean Section and Tubal Ligation (see footnote for definition of 'complicated')	4C	5,300*	6,500*	1,310*	2,100*
28	SI815U	Uterus, Fibroids, Myomectomy (complicated, >5cm, multiple >2, challenging location)	5A	6,400	9,650*	1,310	1,700
		Note: The surgeon fee benchmarks are generally applicable for cases of up to 3 to 4 fibroids removed for MIS operations, and for up to 8 fibroids for open surgeries. Doctors should exercise discretion in ensuring reasonable charges for cases above that number in accordance to effort required and be prepared to explain if necessary.					
29	SI712U	Uterus, Sub-total/Total Hysterectomy (≥12 weeks), with/without Salpingo-Oophorectomy	5A	7,500	10,450	1,670	2,400
		Note: Surgeon fee benchmarks are not applicable to subtotal hysterectomy, which is usually not clinically recommended. If conducted, the fees for subtotal hysterectomy should generally not be higher than that for total hysterectomy.					

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
30	SI812U	Uterus, Endometriosis, Hysterectomy with/without Salpingo-Oophorectomy	5C	6,450	10,250	1,445	1,900
31	SI804U	Uterus, Broad Ligament Tumor, Hysterectomy	5C	6,700	10,450	1,490	1,950
32	SI825U	Uterus, Malignant Condition, Radical Hysterectomy with/without lymphadenectomy Note: Higher end of surgeon fees may be associated with the removal of more lymph nodes and more extensive surgical dissection. Complex cases may require technical skills from sub-specialists.	5C	9,000	14,450	2,030	3,250
33	SI800O	Ovary, Malignant Tumor/Cyst, Total Hysterectomy Bilateral Salpingo-Oophorectomy with Omentectomy, Surgical Staging with/without Lymphadenectomy	5C	12,650	16,050	2,390	3,450

SJ – Endocrine

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
1	SJ701T	Thyroid, Various Lesions, Imaging Guided Percutaneous Aspiration / Biopsy	1B	440	900	500	750
		Note: Higher end of surgeon fees may be associated with biopsies of more lesions e.g. >3.					
2	SJ802T	Thyroid, Various Lesions, Hemithyroidectomy/Partial Thyroidectomy	4A	6,400	8,450	1,580	2,300
3	SJ803T	Thyroid, Various Lesions, Total/Subtotal Thyroidectomy	5C	6,400	11,750	1,805	2,600
		Note: Higher end of surgeon fees may be associated with altered anatomy, larger thyroid or recurrent surgery.					

SK – Nervous

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
1	SK711S	Paravertebral Region - Block, anaesthetic (more than 2 levels)	2A	1,250	2,150	500	800
2	SK717N	Nerve (Upper Limb), Carpal Tunnel Syndrome, Release (unilateral) (with Endoneurolysis)	3A	2,150	3,350	545	800
3	SK705S	Spine, Facet Joint, Radiofrequency, More than 3 joints	4A	4,300	6,400	770	1,100
		Note: Higher end of surgeon fees are associated with treatment for more joints.					

SL – Eye

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
1	SL846E	Eyelids, Tumor, Shaving Excision Note: Higher end of surgeon fees may be associated with a large tumor, or an excision involving a large skin area	1A	300	1,000	545	850
2	SL700V	Vitreous, Intravitreal Injections	1A	690	1,450*	Not available	Not available
3	SL723E	Eyelids, Chalazion or Stye excision under General Anaesthesia Note: Higher end of surgeon fees may be associated with excision of larger or multiple chalazions/ styes.	1A	850	1,450	545	850
4	SL815L	Lens, Various Lesions, Yag Laser Capsulotomy	1C	960	1,600	Not available	Not available
5	SL801I	Iris, Various Lesions, Iridectomy/Iridotomy	2C	1,050	1,950	Not available	Not available
6	SL704R	Retina/Macula, Grid and focal laser photocoagulation	3A	1,600	2,600	Not available	Not available
7	SL803C	Conjunctiva, Pterygium, Removal with conjunctival graft	3A	1,700	2,750	500	800
8	SL805R	Retina, Tears, Photocoagulation (laser) (Unilateral)	3B	1,650	2,350	Not available	Not available
9	SL700R	Retina, Laser retinopexy, complex (subretinal fluid, vitreous haemorrhage, multiple tears)	3B	2,150	3,200	Not available	Not available
10	SL804R	Retina, Tears, Cryotherapy or Photocoagulation (laser) (Bilateral)	3C	1,700	3,050	Not available	Not available
11	SL808L	Lens, Cataract, Extraction with Intra-ocular Lens Implant (Unilateral Left)	4A	2,550	3,950	500	800

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
12	SL809L	Lens, Cataract, Extraction with Intra-ocular Lens Implant (Unilateral Right)	4A	2,550	3,950	500	800
13	SL834E	Eyelids, Ptosis, Correction Levator Palpebrae Superioris Resection (unilateral)	4B	3,100	4,800	770	1,100
14	SL807L	Lens, Cataract, Extraction with Intra-ocular Lens Implant (Bilateral)	5A	4,300	6,000	770	1,250
15	SL810L	Lens, Cataract, Extraction with Intra-ocular Lens Implant and Trabeculectomy with/without antimetabolites	5A	4,300	6,200	770	1,250
16	SL833E	Eyelids, Ptosis, Correction Levator Palpebrae Superioris Resection (bilateral)	5B	5,350	8,000	1,130	1,650
17	SL701V	Vitreous, Various Lesions, Complex Posterior Vitrectomy (PVR, GRT, trauma)	6B	6,400	11,750	1,670	2,400
18	SL801V	Vitreous, Various Lesions, Posterior Vitrectomy (pars plana/ sclerotomy/ lensectomy-extraction with Intra-ocular Lens Implant/ endolaser/ membrane peels)	6B	8,560	12,850	1,895	2,750

SM – Ear, Nose and Throat (ENT)

S/N	TOSP	Description	Table No.	Surgeon Fee Benchmarks		Anaesthetist Fee Benchmarks	
				Lower bound ($)	Upper bound ($)	Lower bound ($)	Upper bound ($)
1	SM700N	Nose, Nasoendoscopy/Nasopharyngolaryngoscopy (single or repeat examinations, during a 90 day global period) Note: Lower end of surgeon fees may be associated with follow up /repeat scopes for a previously known condition	1A	160	380	Not available	Not available
2	SM831E	Ear, Tympanic Membrane, Unilateral,myringotomy without tube	1B	440	1,050	500	800
3	SM700I	Inferior Turbinate reduction (submucous diathermy/radiofrequency)	1C	450	1,600	545	800
4	SM832E	Ear, Tympanic Membrane, Unilateral myringotomy with tube	2A	680	2,150	500	800
5	SM708E	Ear, Tympanic Membrane, Bilateral myringotomy with tube	2B	1,150	3,450	590	950
6	SM714N	Nose, Various Lesions (turbinates), turbinectomy/turbinoplasty/Submucous Resection (with or without endoscopes)	2C	1,050	2,900	500	800
7	SM705T	Tonsils, Various Lesions, Removal with/without Adenoidectomy	3B	4,050	5,350	950	1,500
8	SM709S	Sinuses - Nasal, Infection, Functional Sinuscopic Ethmoidectomy (Unilateral)	4A	5,050	7,650	1,220	1,600
9	SM703S	Sinuses - Nasal, Infection, Functional Sinuscopic Ethmoidectomy (Bilateral)	5A	6,500	9,150	1,670	2,150
10	SM714S	Sinuses - Nasal, Various Lesions, Fronto-nasal Ethmoidectomy with/without Sphenoidotomy	5C	6,700	10,300	1,670	2,150

Annex C

Fee Benchmarks for Doctors' Inpatient Attendance Fees (As of 29 Dec 2020)

The fee range for office hours is for daily fees covering the routine number of visits a doctor may make to see the patient within the day. This includes both the first visit and repeat visits, for the management of the patient on the same day.

Ward Type	Office Hours*
	per day
General Ward	$200 to $400
High Dependency Unit	$250 to $500
Intensive Care Unit *(Lower intensity ICU cases)*	$300 to $600

**Office hours may vary depending on the doctor's practice, but typically around 9- to 10-hour cycle on a weekday (e.g. 8am to 6pm) and 4- to 5- hour cycle on Saturday (e.g. 8am to 1pm).*

The recommended fee benchmarks for inpatient attendance fees should be read in conjunction with the following points:

1. What is an inpatient attendance – **Inpatient attendances cover professional consultations or reviews for a patient who is already hospitalised**, during which the doctor evaluates the patient's health-related issues, formulates a management plan in relation to one or more health-related issues for the patient, provides advice to the patient, including appropriate preventive health care, and records the clinical detail of the service provided to the patient.

2. Reference but not fee cap – The benchmarks serve as a reference of reasonable fee ranges in the private sector and are not a cap that has to be strictly adhered to. Charges that are higher than the benchmarks may not be unreasonable, particularly where a case is unusual in its context or complexity and requires significantly more time or effort. Doctors can charge outside of the fee benchmarks, with valid justification. However, they should inform the patient and the insurer (where applicable) before or during the admission, except when circumstances do not permit him / her to do so.

3. Typical cases – The benchmarks are meant to cover routine cases (that are typical for the specialty). Each benchmark is a range of fees, to cater for some variation in patients' conditions, but they exclude patients whose conditions are of high complexity or very ill.

4. What the fee range covers –

    a. The fee covers the professional consultation only and does not include costs of medications, injections, operations, special procedures, investigations (e.g. radiological and laboratory tests), etc.

    b. Fee ranges are applicable for all doctors, regardless of specialty.

Additional notes on what the ICU fee range covers

    c. The ICU fee benchmarks is **applicable only for ICU cases requiring lower intensity of management and monitoring**. This may include patients who require post-surgical monitoring and observation, or with single organ failure and/ or impending or established respiratory failure requiring the use of ventilatory support (invasive/non-invasive) for acute respiratory conditions.

    d. The ICU fee range is **NOT applicable to medium to high intensity ICU cases.** This may include patients with 2 or more acute organ failures, and/ or additional management involving the use of extracorporeal membrane oxygenation, and renal replacement therapy, etc.

    e. The lower end of the ICU fee benchmark would be more relevant if a doctor’s effort for the professional attendance is similar to a routine consultation in the general ward.

5. How to use the fee range –

    a. The lower end of the fee benchmark is generally for straightforward professional consultations or reviews which involve short visits, a short patient history and if required, limited examination and management, for example, a routine post-operation review.

    b. The higher end of the fee benchmark is generally for the first consultation and/or cases requiring more complex or extended consultations where more time and expertise are needed for extensive history-taking, clinical examination, arranging any necessary investigation, diagnosis, implementing a treatment or management plan, and advice or discussion with the patient and family.

6. Fee benchmarks for after-office hours services – The fee range for after-office hours and after midnight hours is for **each visit** a doctor may be called back for a review or consultation on top of the day's routine consultations or visits during office hours.

Ward Type	**After-office Hours^**	
	Before midnight	**After midnight**
	per visit	
General Ward	$200 to $300	$300 to $400
High Dependency Unit	$250 to $350	$350 to $500
Intensive Care Unit *(Lower intensity ICU cases)*	$300 to $450	$450 to $600

^Usually refers to visits where a doctor is called back on top of the routine consultations or reviews during office hours.

For call-back charges after-office hours, doctors may reasonably factor in the time of the visit, as well as the effort and duration required for the visit. In such cases, doctors are advised to clearly inform patients of their office hours and the additional charges.

7. Goods and Services Tax (GST) – The benchmarks exclude GST.