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CONTENTS

GENERAL NOTICE

NOTICE 1830 OF 2006

DEPARTMENT OF TRANSPORT

PUBLICATION FOR PUBLIC COMMENTS: ROAD ACCIDENT FUND ACT, 1996(ACT No.56 of 1996), REGULATIONS

The Minister of Transport has, under section 26 of the Road Accident Fund Act, 1996(Act No. 56 of 1996), as amended, made the Regulations in the Schedule hereto for public comments. Interested persons are invited to submit written comments on the regulations by not later than 31 January 2007. Submission should be posted to the Director – General for the attention of Marius Luyt at:

The Department of Transport
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0001

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DEPARTMENT OF TRANSPORT

No. R. .. Date

ROAD ACCIDENT FUND ACT, 1996

REGULATIONS

The Minister of Transport has, under section 26 of the Road Accident Fund Act, 1996 (Act No. 56 of 1996), as amended, made the Regulations in the Schedule hereto.

SCHEDULE

1 Definitions

In these Regulations, unless the context otherwise indicates, any expression to which a meaning has been assigned in the Act bears the meaning so assigned

2 Further provision for liability of Fund in terms of section 17(1)*(b)*

(1) In the case of any claim for compensation referred to in section 17(1)*(b)* of the Act, the Fund shall not be liable to compensate any third party unless–

(a) the bodily injury or death concerned arose from the negligent or other wrongful driving of the motor vehicle concerned;

(b) the third party took all reasonable steps to establish the identity of the owner or the driver of the motor vehicle concerned; and

(c) the third party submitted, if reasonably possible, within 14 days after being in a position to do so an affidavit to the police in which particulars of the occurrence concerned were fully set out.

(2) The liability of the Fund in the case of any claim for compensation referred to in section 17(1)*(b)* of the Act shall not exceed the amount for which the Fund would have been liable had it been a claim for compensation referred to in section 17(1)*(a)* of the Act.

(3) A claim for compensation referred to in section 17(1)*(b)* of the Act shall be sent or delivered to the Fund, in accordance with the provisions of section 24 of the Act, within two years from the date upon which the claim arose, irrespective of any legal disability to which the third party concerned may be subject and notwithstanding anything to the contrary in any law.

(4) The liability of the Fund in respect of any claim sent or delivered to it as provided for in subregulation (3) shall be extinguished upon the expiry of a period of five years from the date upon which the claim arose, irrespective of any legal disability to which the third party concerned may

be subject and notwithstanding anything to the contrary in any law, unless a summons to commence legal proceedings has been properly served on the Fund before the expiry of the said period

(5) The Fund shall at any time after having received a claim for compensation referred to in section 17(1)*(b)* of the Act be entitled to require the third party concerned to submit to questioning by the Fund at a place indicated by the Fund and to make a sworn statement fully setting out the circumstances of the occurrence concerned, and the Fund shall not be liable for compensation if the third party fails or refuses to comply with any requirement in terms of this subregulation.

(6) The liability of the Fund in the case of any claim for compensation referred to in section 17(1)*(b)* of the Act shall be subject to the provisions of the Act and of these Regulations only to the extent that those provisions are consistent with this regulation and capable of being applied in the circumstances mentioned in the said section 17(1)*(b)*.

(7) If any claimant, whether a third party referred to in section 17(1) or a supplier referred to in section 17(5), fails to furnish in the claim form concerned the information required to be furnished therein to enable the Fund or an agent to establish the identity of the actual driver or owner of the motor vehicle concerned at the time of the occurrence concerned, the claim of that claimant shall be subject to the provisions of this regulation

3 Assessment of serious injury in terms of section 17(1A)

(1) *(a)* A third party wishing to claim compensation for non-pecuniary loss as contemplated in the proviso to section 17(1) of the Act, shall submit him- or herself to an assessment by a medical practitioner in accordance with this regulation.

(b) A medical practitioner referred to in paragraph *(a)* shall assess the third party's bodily injury for the purpose of establishing whether and, if so, in what degree the bodily injury results in an Impairment of the Whole Person, as contemplated in the AMA Guides.

(c) In this regulation "AMA Guides" means the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, Fifth Edition, or such subsequent edition thereof as the Fund may from time to time give notice of in the *Gazette*.

(2) *(a)* An injury that is assessed as equating to a percentage of Impairment of the Whole Person, as contemplated in the AMA Guides, of 30 or more, shall be regarded as a serious injury for the purposes of section 17 of the Act and of this regulation.

(b) A third party whose injury has been assessed as equating to 30 per cent or more Impairment of the Whole Person, as referred to in

paragraph *(a)*, shall obtain from the medical practitioner concerned a written report stating the medical practitioner's substantiated finding and the relevant percentage.

(3) A claim for compensation for non-pecuniary loss as contemplated in the proviso to section 17(1) of the Act shall be–

(a) accompanied by the report referred to in subregulation (2)*(b)*; and

(b) lodged, in accordance with the requirements of section 24(1)*(b)* of the Act and of regulation 8(1),–

(i) within the period of three years referred to in section 23(1) of the Act, read with section 23(2) of the Act, in the case of a claim for compensation referred to in section 17(1)*(a)* of the Act; or

(ii) within the period of two years referred to in regulation 2(3), in the case of a claim for compensation referred to in section 17(1)*(b)*

(4) If maximal medical improvement, as contemplated in the AMA Guides, in respect of a third party's injury has not yet been reached when the relevant period required by subregulation (3)*(b)*(i) or (ii) is about to expire, the injury shall be assessed prior to the expiry of the said period, notwithstanding anything to the contrary contained in the AMA Guides

(5) The Fund or an agent may, at the request of a third party, make available to the third party the services of, or, alternatively, refer the third party to–

(a) a medical practitioner for purposes of an assessment in accordance with this regulation, and

(b) a person providing health services in terms of any law, including the Allied Health Professions Act, 1982, the Health Professions Act, 1974, the Nursing Act, 1978, the Pharmacy Act, 1974, and the Dental Technicians Act, 1979, for purposes of collecting and collating information to facilitate such an assessment.

(6) The cost of an assessment in accordance with this regulation shall be borne by the Fund or an agent only if the third party's injury is found to be serious and the Fund or the agent attracts overall liability in terms of the Act.

(7) In the event of either the third party or the Fund or an agent disputing any aspect of the assessment performed by a medical practitioner in terms of this regulation, the disputing party shall–

(a) in writing and within 90 days of being advised of the assessment notify the registrar of the Health Professions Council of South Africa established in terms of section 2 of the Health Professions Act, 1974, that the assessment is disputed,

(b) in such notification set out the grounds upon which the assessment is disputed and include such submissions, medical reports and opinions as the disputing party seeks to rely upon; and

(c) in the event that the disputing party is the Fund or an agent provide all available contact details pertaining to the third party

(8) The registrar referred to in subregulation (7)*(a)* shall within 14 days of having been notified of a dispute as envisaged in subregulation (7), notify in writing and provide copies of all the submissions, medical reports and opinions submitted by the disputing party to–

(a) the third party, in the event that the disputing party is the Fund or an agent; alternatively

(b) the Fund or the agent, in the event that the disputing party is the third party

(9) In the event that the Fund or an agent, or the third party, as the case may be, is notified of a dispute in terms of subregulation (8), the Fund or the agent, or the third party, as the case may be, shall–

(a) in writing and within 60 days of being advised of the dispute notify the registrar referred to in subregulation (7)*(a)* which submissions medical reports and opinions submitted by the disputing party it, he or she places in dispute; and

(b) in such notification set out such submissions, medical reports and opinions as it, he or she seeks to rely upon

(10) The dispute arising from such documents as are submitted to the registrar of the Health Professions Council of South Africa in terms of subregulations (7) and (9) shall be referred for consideration by an appeal tribunal consisting of three independent medical practitioners with expertise in the appropriate areas of medicine, appointed by the said registrar, who shall designate one of them as the presiding officer of the appeal tribunal.

(11) The appeal tribunal referred to in subregulation (10) shall have the following powers:

(a) Direct that further submissions be made by the third party and the Fund or an agent, and stipulate the time frame within which such further submissions must be placed before the appeal tribunal.

(b) Direct that further medical reports be procured and placed before the appeal tribunal by one or more of the parties.

(c) Direct that treatment records pertaining to the third party be procured and made available to the appeal tribunal

(d) Summons the third party, on no less than five days' written notice, to make him- or herself available for a clinical examination by one or more members of the appeal tribunal

(e) Assess the third party's bodily injury in accordance with the AMA Guides.

(f) Determine whether in its majority view the injury concerned is assessed as equating to a percentage of Impairment of the Whole Person, as contemplated in the AMA Guides, of 30 or more.

(g) Substitute its assessment for the assessment performed by the medical practitioner, provided the majority of the members of the appeal tribunal is of the view that it is appropriate to replace the assessment of the medical practitioner.

(12) The appeal tribunal shall publish its findings pursuant to its consideration of the dispute within 180 days of the registrar referred to in subregulation (7)*(a)* having been notified of the dispute by the disputing party, alternatively such additional period as the said registrar may on application from the appeal tribunal authorise in writing

(13) The Fund shall bear the reasonable costs of the Health Professions Council of South Africa arising from subregulations (7) to (12), as agreed between the Fund and the said Council, or, failing such agreement, as determined by the Minister after consultation with the Minister of Health

4 Further provision in respect of claim for loss of income or support in terms of section 17(4)*(c)*

(1) In proportionately calculating the annual loss of income or support referred to in section 17(4)*(c)* of the Act, such loss shall be calculated per fiscal year.

(2) In this regulation "fiscal year" means the period commencing on the first day of March of any given year and ending on the last day of February of the subsequent year

5 Medical tariffs

(1) The liability of the Fund or an agent in respect of the costs of the accommodation of any person in a hospital or nursing home or the treatment of or rendering of a service or supplying of goods to any person, shall be determined–

(a) in accordance with the Uniform Patient Fee Schedule for fees payable to public health establishments by full-paying patients, prescribed under section 90(1)*(b)* of the National Health Act, 2003, as revised from time to time; alternatively,

(b) in the case only of emergency medical treatment referred to in section 17(4B)(*b*) of the Act, in accordance with the tariff set out in Annexure A to these Regulations.

(2) The liability of the Fund or an agent in terms of this regulation shall be subject to the submission to the Fund or the agent, of an original and itemized invoice or account clearly identifying–

(a) the service provider who rendered the service or provided the goods concerned, and

(b) the recipient of the service or goods, as well as the person liable for payment of the account concerned, if they are not the same

(3) The liability of the Fund or an agent, in circumstances where provision is not made under subregulation (1), for the costs of the future accommodation of any person in a hospital or nursing home or the treatment of or rendering of a service or supplying of goods to any person, including but not limited to the costs of alterations to a building or premises, or modification of a motor vehicle, shall be based on the lowest of any reasonable quotation either submitted to or obtained by the Fund or the agent.

6 Further provision for liability of Fund or agent in terms of section 18(4)

The liability of the Fund or an agent in respect of any funeral expenses referred to in section 18(4) of the Act shall be subject to the submission to the Fund or the agent, of an original and itemized invoice or account clearly identifying–

(a) the service provider who rendered the service, or provided the goods, and

(b) the person liable for payment of the account concerned.

7 Provision for recovery of wasted costs related to medical examinations in terms of section 19*(e)*(i)

(1) The Fund or an agent may recover from a claimant under section 17 of the Act, any wasted costs incurred by the Fund or the agent as a result of the failure of any person contemplated in section 19*(e)* of the Act to attend any medical examination scheduled by the Fund or the agent in terms of section 19*(e)*(i) of the Act: Provided that the Fund or the agent notified the claimant concerned in writing of the date, time and venue of the examination, and, where applicable, of any further details in respect of arrangements made which are incidental to the scheduled examination.

(2) For the purposes of this regulation "wasted costs" includes, but is not limited to, travelling and accommodation costs.

(3) Where the claimant, upon affidavit, furnishes the Fund or the agent with acceptable reasons for the failure to attend the medical examination concerned, the Fund or the agent may elect not to pursue the recovery of such wasted costs.

8 Further provision for procedure matters contemplated in section 24

(1) Any reference in section 24(1)*(b)* of the Act to the Fund's principal, branch or regional office, or to an agent's registered office or local branch office, shall for the purposes of compliance with that paragraph, refer to such principal, branch or regional office of the Fund, or registered office or local branch office of an agent, as the case may be,–

(a) which is situated nearest to the location where the occurrence from which the claim arose took place; or
(b) which is situated nearest to the location where the third party resides

(2) The Fund or an agent shall at any time after having received a claim for compensation referred to in section 17(1)*(a)* of the Act be entitled to require the third party concerned to submit to questioning by the Fund or the agent at a place indicated by the Fund or the agent and to make a sworn statement fully setting out the circumstances of the occurrence concerned

(3) Subject to section 15(2) of the Act, for the purposes of establishing jurisdiction to issue the summons referred to in section 24(6) of the Act, the Fund's or an agent's principal place of business shall be the principal, branch or regional office of the Fund, or the registered office or local branch office of the agent, as the case may be, where the claim concerned is being administered.

(4) The Fund or an agent may effect payment of any compensation payable to a third party or supplier directly to the third party or supplier, notwithstanding that third party or supplier being represented by any other person.

9 Forms

(1) A claim for compensation and accompanying medical report referred to in section 24(1)*(a)* of the Act shall be combined in the form RAF 1 set out in Annexure B to these Regulations.

(2) A claim by a supplier referred to in section 24(3) of the Act shall be in the form RAF 2 set out in Annexure B to these Regulations.

(3) The particulars and statements referred to in section 22(1)*(a)* of the Act shall be furnished to the Fund in the form RAF 3 (called an Accident Report Form) set out in Annexure B to these Regulations.

10 Repeal of Regulations

Subject to regulation 11 the Regulations published on 25 April 1997 under Government Gazette No R 609 are hereby repealed and replaced by these Regulations

11 Savings

These Regulations shall not apply to any claim for compensation under section 17 of the Act in respect of which the cause of action arose prior to the date on which these Regulations came into operation, and any such claim shall be dealt with as if these Regulations had not come into operation.

12 Commencement

These Regulations shall come into operation on .

ANNEXURE A

TARIFF FOR EMERGENCY MEDICAL TREATMENT

(SECTION 17(4B)(*b*) OF ACT NO. 56 OF 1996 AND REGULATION 5(1)(*b*) OF THE REGULATIONS UNDER THE ACT)

NOTE: In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10 cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme must be followed.
ALL PRICES ARE VAT EXCLUSIVE.

SERVICES BY MEDICAL PRACTITIONERS		
RULES GOVERNING THE TARIFF		
A.	Consultations: Definitions: (a) New and established patients: A consultation/visit refers to a clinical situation where a medical practitioner personally obtains a patient's medical history, performs an appropriate clinical examination and, if indicated, administers treatment, prescribes or assists with advice. These services must be face-to-face with the patient and excludes the time spent doing special investigations which receive additional remuneration. (b) Subsequent visits: Refers to a voluntarily scheduled visit performed within four (4) months after the first visit. It may imply taking down a medical history and/or a clinical examination and/or prescribing or administering of treatment and/or counselling. (c) Hospital visits: Where a procedure or operation was done, hospital visits are regarded as part of the normal after-care and no fees may be levied (unless otherwise indicated). Where no procedure or operation was carried out, fees may be charged for hospital visits according to the appropriate hospital or inpatient follow-up visit code.	04.00
B.	Normal hours and after hours: After-hours services are paid at the same rate as benefits for normal hours services. Bona fide emergency medical services rendered to a patient, at any time, may attract a fee as specified in modifier 0011 and items 0146 or 0147 (which should be added to the appropriate consultative services code selected from items 0190-0192, 0173-0175, 0161-0164, 0166-0169)	06.04
C.	Comparable services: A service may be rendered that is not listed in this edition of the coding structure. The fee that may be charged in respect of the rendering of a service not listed in this coding structure shall be based on the fee in respect of a comparable service. For these procedure(s)/service(s), item 6999: Unlisted procedure or service code, should be used. Please contact the SA Medical Association (SAMA) Private Practice Unit via e-mail on coding@samedical.org to obtain a comparable code for the unlisted procedure/service which will be based on the fee for a comparable service in the coding structure. When item 6999 is used to indicate that an unlisted service was rendered, the use of the item must be supported by a special report. This report must include: (1) An adequate definition or description of the nature, extent and need for the procedure/service or "medical necessity"; (2) In which respect is this service unusual or different in technique, compared to available procedures/services listed in the coding structure? Information regarding the nature and extent of the procedure/service, time and effort, special/dedicated equipment needed to provide this service, must be included in the report; (3) Is this procedure/service medically appropriate under the circumstances? Explain why another procedure/service listed in the coding structure will not be appropriate in this case; (4) A description of the complexity of the symptoms and concurrent problems must be supplied; (5) Final diagnosis supported by the appropriate ICD-10 code(s); (6) Pertinent physical findings (size, location and number of lesions if applicable); (7) Mention any other diagnostic or therapeutic procedure(s)/service(s) provided at the same session; (8) Any further diagnostic or therapeutic procedure(s)/service(s) to be provided in the follow-up period; and (9) Description of the follow-up care needed. Please note: This comparable service code may not be used for a period longer than six months for a particular procedure /service after which time an application has to be made to the Fund for the addition of a specific code or for an extension of time.	05.02
D.	Cancellation of appointments: Unless timely steps are taken to cancel an appointment for a consultation, the relevant consultation fee may be charged. In the case of a general practitioner "timely" shall mean two hours and in the case of a specialist 24 hours prior to the appointment. Each case shall, however, be considered on merit and, if circumstances warrant, no fee shall be charged. If a patient has not turned up for a procedure, each member of the surgical team is entitled to charge for a visit at or away from doctor's rooms as the case may be	04.00
E.	Pre-operative visits: The appropriate fee may be charged for all pre-operative visits with the exception of a routine pre-operative visit at the hospital	04.00
F.	Administering of injections and/or infusions: Where applicable, fees for administering injections and/or infusions may only be charged when done by the practitioner himself	04.00

G.	Post-operative care: (a) Unless otherwise stated, the fee in respect of an operation or procedure shall include normal after-care for a period not exceeding ONE month (after-care is excluded from pure diagnostic procedures during which no therapeutic procedures were performed). (b) If the normal after-care is delegated to any other 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. (c) When post-operative care/treatment of a prolonged or specialised nature is required, such fee as may be agreed upon between the surgeon and the Fund or the patient (in case of a private account) may be charged. (d) Normal after-care refers to an uncomplicated post-operative period not requiring any further incisions	04.00
H.	Removal of lesions: Items involving removal of lesions include follow-up treatment for 10 days	04.00
I.	Practice of specialists: In terms of the conditions in respect of the practice of specialists as published in Government Gazette No. 12958 of 11 January 1991, a specialist may treat any person who comes to him direct for consultation. A specialist who is consulted by a patient or who treats a patient, shall take all reasonable steps to ensure the collaboration of the patient's general practitioner.	04.00
J.	Procedures performed at time of visits: If a procedure is performed at the time of a consultation/visit, the fee for the visit PLUS the fee for the procedure is charged	04.00
M.	Procedure planned to be performed later: 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	04.00
K.	"Per consultation": No additional fee may be charged for a service for which the fee is indicated as "per consultation". Such services are regarded as part of the consultation/visit performed at the time the condition is brought to the doctor's attention	04.00
L.	Costly or prolonged medical services or procedures: In the case of costly or prolonged medical services or procedures, the medical practitioner shall first ascertain from the Fund for what amount the will accept responsibility in respect of such treatment, should the practitioner wish any direct payment from the Fund	04.00
M.	Travelling fees: (a) Where, in cases of emergency, a practitioner was called out from his residence or rooms to a patient's home or the hospital, travelling fees can be charged according to the section on travelling expenses (section IV) if he had to travel more than 16 kilometres in total. (b) If more than one patient would be attended to during the course of a trip, the full travelling expenses must be divided between the relevant patients. (c) A practitioner is not entitled to charge for any travelling expenses or travelling time to his rooms. (d) Where a practitioner's residence would be more than 8 kilometres away from a hospital, no travelling fees may be charged for services rendered at such hospitals, except in cases of emergency (services not voluntarily scheduled). (e) Where a practitioner conducts an itinerant practice, he is not entitled to charge fees for travelling expenses except in cases of emergency (services not voluntarily scheduled). (f) For voluntarily scheduled services, fees for travelling expenses may only be charged where the patient and the practitioner have entered into an agreement to this effect. The Fund benefits will not be applicable in such instances.	04.00
N.	Intensive care/High Care: Units in respect of items 1204 to 1210 (Categories 1 to 3) EXCLUDE the following: (a) Anaesthetic and/or surgical fees for any condition or procedure, as well as a first consultation/visit, which is, regarded as the assessment of the patient, while the daily intensive care/high care fee covers the daily care in the intensive/high care unit. (b) Cost of any drugs and/or materials. (c) Any other cost which may be incurred before, during or after the consultation/visit and/or the therapy. (d) Blood gases and chemistry tests, including the arterial puncture to obtain the specimen. (e) Procedural items 1202 and 1212 to 1221. but INCLUDE the following: (f) Performing and interpretation of a resting ECG. (g) Interpretation of chemistry tests and x-rays. (h) Intravenous treatment (items 0206 and 0207), except intravenous infusion in patients under the age of three years (item 0205) that does not form a part of the daily ICU/High Care fee and may be charged for separately on a daily basis (fee includes the introduction of the cannula as well as the daily management)	06.05
O.	Multiple organ failure: Units for items 1208, 1209 and 1210 (Category 3: Cases with multiple organ failure) include resuscitation (i.e. item 1211: Cardio-respiratory resuscitation)	04.00
P.	Ventilation: Units for items 1212, 1213 and 1214 (ventilation) include the following: (a) Measurement of minute volume, vital capacity, time- and vital capacity studies. (b) Testing and connecting the machine. (c) Putting patient on machine: setting machine, synchronising patient with machine. (d) Instruction to nursing staff. (e) All subsequent visits for 24 hours.	04.00
Q.	Ventilation (items 1212 to 1214) does not form a part of normal post-operative care, but may not be added to item 1204: Catogory 1: Cases requiring intensive monitoring	04.00
R.	Obstetric procedures: (a) When a general practitioner treats a patient in the ante-natal period and, after starting the confinement, requests an obstetrician to take over the case, the general practitioner shall be entitled to charge for all the ante-natal consultations he/she has performed. (i) If the patient has been in labour for less than 6 hours, the general practitioner shall charge 50,00 clinical procedure units according to item 2614: Global obstetric care. (ii) If the patient has been in labour for more than 6 hours, the general practitioner shall charge 80,00 clinical procedure units according to item 2614: Global obstetric care. (b) When a general practitioner calls an obstetrician to help with a confinement, take over the management of a confinement, and treats the patient until after the post-partum visit, the obstetrician shall charge according to item 2614: Global obstetric care. (c) When a general practitioner calls an obstetrician (specialist or general practitioner) to help with a confinement, or take over the management of a confinement, but the general practitioner treats the patient until after the post-partum visit, the obstetrician shall charge according to item 2616: Intrapartum obstetric care by obstetrician in consultation, and the general practitioner according to item 2614: Global obstetric care.	04.00

S.	(a) Electro-convulsive treatment: Visits at hospital or nursing home during a course of electro-convulsive treatment are justified and may be charged for in addition to the fees for the procedure. (b) Except where otherwise indicated, the duration of a medical psychotherapeutic session is set at 20 minutes or part thereof, provided that such a part comprises 50% or more of the time of a session. This set duration is also applicable for psychiatric examination methods	04.00
T.	Except where otherwise indicated, radiologists are entitled to charge for contrast material used	04.00
U.	No fee is subject to more than one reduction	04.00
V.	Procedures to exclude cost of isotope	04.00
W.	The fees in this section (radiation oncology) do NOT include the cost of radium or isotopes	04.00
X.	Ultrasound examinations: The international norm approved for use in South Africa for NORMAL PREGNANCY is two ultrasound exams: (a) The first scan should preferably include a nuchal thickness estimation and be performed between 10 and 14 weeks gestation. The second scan should be performed between 20 and 24 weeks and should include a full anatomical report. All subsequent ultrasound scans are excluded from the benefits unless accompanied by proper motivation. An ultrasound scan to assess an abnormal early pregnancy may be formed before 10 weeks but this scan may not be used to diagnose a normal uncomplicated pregnancy. Item 3618 is a gynaecological scan and its use is not approved for use in pregnancy. (b) In cases where the scan is performed by the attending practitioner, a clear indication for such a scan must be entered on the account rendered, or a letter of motivation must be attached to the account (the practitioner must elect one of the two options). (c) In case of a referral, the referring doctor must submit a letter of motivation to the radiologist or other practitioner doing the scan. A copy of the letter of motivation must be attached to the first account rendered to the patient (by the radiologist or the other practitioner doing the scan) and must be attached to the first account submitted to the Fund by the patient or the doctor, as the case may be. (d) In case of a referral to a radiologist, no motivation should be required from the radiologist	04.00
Y.	(a) When a cystoscopy precedes a related operation, Modifier 0013: Endoscopic examination done at an operation, applies, e.g. cystoscopy followed by transurethral (TUR) prostatectomy. (b) When a cystoscopy precedes an unrelated operation, Modifier 0005: Multiple procedures/operations under the same anaesthetic, applies, e.g. cystoscopy for urinary tract infection followed by inguinal hernia repair. (c) No modifier applies to item 1949: Cystoscopy, when performed together with any of items 1951 to 1973.	04.00
Z.	Capturing and recording of examinations: Images from all radiological, ultrasound and magnetic resonance imaging procedures must be captured during every examination and a permanent record generated by means of film, paper, or magnetic media. A report of the examination, including the findings and diagnostic comment, must be written and stored for five years	04.00
AA.	The radiology section in this price list is not for use by registered specialist radiology practices (Pr No "038") or nuclear medicine practices (Pr No "025"), but only for use by other specialist practices or general practitioners. A separate radiology schedule is for the exclusive use of registered specialist radiology practices (Pr No "038") and nuclear medicine practices (Pr No "025").	04.00
BB.	Diagnostic services rendered to hospital inpatients: Quote Modifier 0091 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients officially admitted to hospital or day clinic	04.00
CC.	Diagnostic services rendered to outpatients: Quote Modifier 0092 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients NOT officially admitted to hospital or day clinic (could be within the confines of a hospital)	04.00
MODIFIERS GOVERNING THE STRUCTURE		
0002	Written report on X-rays: The lowest level code for a new patient office (consulting rooms) visit is applicable only where a radiologist is requested to give a written report on X-rays taken elsewhere and submitted to him. The above mentioned item and the lowest level initial hospital visit code, as appropriate are not to be used for routine reporting of X-rays taken elsewhere	04.00
0004	Procedures performed in own procedure rooms: Procedures performed in doctors' own procedure rooms instead of in a hospital theatre or unattached theatre unit: as per fee for procedure + 100% (the value of modifier 0004 equals 100% of the value of the procedure performed). See Section V (Section G in SAMA's DBT) for a list of procedures, which are often done in rooms to which Modifier 0004 should not be applied. Please note: Only the medical practitioner who owns the facility and the equipment may charge modifier 0004. Only one person may claim this modifier for procedures performed in doctors' own procedure rooms	06.05

0005	Multiple therapeutic procedures/operations under the same anaesthetic: a) Unless otherwise identified in the tariff when multiple therapeutic 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/operations. This modifier does not apply to purely diagnostic procedures. b) In the case of multiple fractures and/or dislocations the above values shall prevail. c) "+" Means that this item is used in addition to another definitive procedure and is therefore not subject to reduction according to Modifier 0005 (see also Modifier 0082)								04.00
0006	Visiting specialists performing procedures: Where specialists visit smaller centres to perform procedures, fees for these particular procedures are exclusive of after-care. The referring practitioner will then be entitled to subsequent hospital visits for after-care. If the referring practitioner is not available, the specialist shall, on consultation with the patient, choose an appropriate locum tenens. Both the surgeon and the practitioner who handled the after-care, must in such instances quote Modifier 0006 with the particular items which they use								04.00
0007	a) Use of own monitoring equipment in the rooms: Remuneration for the use of any type of own monitoring equipment in the rooms for procedures performed under intravenous sedation - 15, 00 clinical procedure units irrespective of the number of items of equipment provided. b) Use of own equipment in hospital theatre or unattached theatre unit: Remuneration for the use of any type of own equipment for procedures performed in a hospital theatre or unattached theatre unit when appropriate equipment is not provided by the hospital - 15,00 clinical procedure units irrespective of the number of items of equipment provided.	04.00		15.000	95.36 (83.65)	15.000	95.36 (83.65)		
0008	Specialist surgeon assistant: Where a procedure requires a registered specialist surgeon assistant, the fee is 33,33% (1/3) of the fee for the specialist surgeon								04.00
0009	Assistant: The fee for an assistant is 20% of the fee for the 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								04.00
0010	Local anaesthesic: (a) A fee for a local anaesthetic administered by the operator may only be charged for (1) an operation or procedure having a value greater than 30, 00 clinical procedure units (i.e. 31, 00 or more clinical procedure units allocated to a single item) or (2) where 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 fee shall be calculated according to the basic anaesthetic units for the specific operation. Anaesthetic time may not be charged for, but the minimum fee as per Modifier 0036: Anaesthetic administered by a general practitioner, shall be applicable in such a case. (c) Not applicable to radiological procedures (such as angiography and myelography. (d) No fee may be levied for topical application of local anaesthetic. (e) Please note: Modifier 0010: Local anaesthetic administered by the operator, may not be added on the surgeon's account for procedures that were performed under general anaesthetic.								04.00
0011	Emergency procedures: 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. (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)								06.04
0013	Endoscopic examinations done at operations: Where a related endoscopic examination is done at an operation by the operating surgeon or the attending anaesthesiologist, only 50% of the fee for the endoscopic examination may be charged								04.00
0014	Operations previously performed by other surgeons: Where an operation is performed which has been previously performed by another surgeon, e.g. a revision or repeat operation, the fee shall be calculated according to the tariff for the full operation								04.00
0015	Intravenous infusions: Where intravenous infusions (including blood and blood cellular products) are administered as part of the after-treatment after the operation or confinement, no extra fees shall be charged as this is included in the global operative or maternity fees. Should the practitioner doing the operation or attending to the maternity case prefer to ask another practitioner to perform post-operative or post-confinement intravenous infusions, then the practitioner himself (and not the patient) shall be responsible for remunerating such practitioner for the infusions								04.00

0017	Injections administered by practitioners: When desensitisation, intravenous, intramuscular or subcutaneous injections are administered by the practitioner him-/herself to patients who attend the consulting rooms, a first injection forms part of the consultation/visit and only all subsequent injections for the same condition should be charged at 7.50 consultative services units using modifier 0017 to reflect the amount (not chargeable together with a consultation item)	05.06		7.500	76.99 (67.54)	7.500	76.99 (67.54)		
0018	Surgical modifier for persons with a BMI of 35> (calculated according to kg/m2): Fee for procedure +50% for surgeons and a 50% increase in anaesthetic time units for anaesthesiologists									04.00
0019	Surgery on neonates (up to and including 28 days after birth) and low birth weight infants (less than 2500g) under general anaesthesia (excluding circumcision): per fee for procedure + 50% for surgeons and a 50% increase in anaesthetic time units for anaesthesiologists									04.00
0046	Where in the treatment of a specific fracture or dislocation (compound or closed) an initial procedure is followed within one month by an open reduction, internal fixation, external skeletal fixation or bone grafting on the same bone, the fee for the initial treatment of that fracture or dislocation shall be reduced by 50%. Please note: This reduction does not include the assistant's fee where applicable. After one month, a full fee as for the initial treatment, is applicable									04.00
0048	Where in the treatment of a fracture or dislocation, an initial closed reduction is followed within one month by further closed reductions under general anaesthesia, the fee for such subsequent reductions will be 27,00 clinical procedure units (not including after-care)	04.00		27.000	171.64 (150.56)	27.000	171.64 (150.56)		
0049	Except where otherwise specified, in cases of compound fractures, 77,00 clinical procedure units (specialists) and 77,00 clinical procedure units (general practitioners) are to be added to the units for the fractures including debridement	04.11		77.000	489.49 (429.38)	77.000	489.49 (429.38)		
0050	In cases of a compound fracture where a debridement is followed by internal fixation (excluding fixation with Kirschner wires, as well as fractures of hands and feet), the full amount according to either Modifier 0049: Cases of compound fractures, or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, may be added to the fee for the procedure involved, plus half of the amount according to the second modifier (either Modifier 0049: Cases of compound fractures or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, as applicable)	04.00		115.50 0	734.23 (644.06)	115.50 0	734.23 (644.06)		
0051	Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting: Specialists add 77,00 clinical procedure units. General practitioners add 77,00 clinical procedure units	04.11		77.000	489.49 (429.38)	77.000	489.49 (429.38)		
0055	Dislocation requiring open reduction: Units for the specific joint plus 77,00 clinical procedure units for specialists. General practitioners add 77,00 clinical procedure units	04.11		77.000	489.49 (429.38)	77.000	489.49 (429.38)		
0061	Combined procedures on the spine: In cases of combined procedures on the spine, both the orthopaedic surgeon and the neurosurgeon are entitled to the full fee for the relevant part of the operation performed									04.00
0063	Where two specialists work together on a replantation procedure, each shall be entitled to two-thirds of the fee for the procedure									04.00
0064	Where the replantation is unsuccessful, no further surgical fee is payable for amputation of the non-viable parts									04.00
0065	Additional operative procedures by same surgeon, under section 3.8.6: Spinal deformities, within a period of 12 months: 75% of scheduled fee for the lesser procedure, except where otherwise specified elsewhere									04.00
0070	Add 45,00 clinical procedure units to procedure(s) performed through a thorascope	04.00		45.000	286.07 (250.94)	45.000	286.07 (250.94)		
0072	Non invasive peripheral vascular tests: The number of tests in a single case is restricted to two (2) per diagnosis. Tests are not justified in cases of uncomplicated varicose veins									04.00
0080	Multiple examinations: Full Fee									04.00
0081	Repeat examinations: No reduction									04.00
0082	"+" Means that this item is complementary to a preceding item and is therefore not subject to reduction									04.00

0083	A reduction of 33,33% (1/3) in the fee will apply to radiological examinations as indicated in section 19: Radiology where hospital equipment is used									04.00
0084	Film costs: In the case of radiological items where films are used, practitioners should adjust the fee upwards or downwards in accordance with changes in the price of films in comparison with November 1979; the calculation must be done on the basis that film costs comprise 10% of the monetary value of the unit (This information is obtainable from the Radiological Society of SA)									04.00
0085	Left Side' modifier to be added to when items 6500 to 6519 are used when the left side is examined. Please note that the absence of this modifier indicates that the right side was examined									04.00
0086	Vascular groups: "Film series" and "Introduction of Contrast Media" are complementary and together constitute a single examination: neither fee is therefore subject to increase in terms of Modifier 0080: Multiple examinations									04.00
0090	Radiologist's fee for participation in a team: 30, 00 radiology units per ½ hour or part thereof for all interventional radiological procedures, excluding any pre- or post-operative angiography, catheterisation, CT-scanning, ultrasound-scanning or x-ray procedures. (Only to be charged if radiologist is hands-on, and not for interpretation of images only)									04.00
0091	Diagnostic services rendered to hospital inpatients: Quote Modifier 0091 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients officially admitted to hospital or day clinic (refer to Rule XX)									04.00
0095	Radiation materials: Exclusively for use where radiation materials supplied by the practice are used by clinical and radiation oncologists, modifier 0095 should be used to identify these materials. This modifier is only chargeable by the practice responsible for the cost of this material and where the hospital did not charge therefore. Please note that item 0201 should not be used for these materials									04.00
0097	Pathology tests performed by non-pathologists: Where items under Clinical Pathology (section 21) and Anatomical Pathology (section 22) fall within the province of other specialists or general practitioners, the fee is to be charged at two-thirds of the pathologists fee									04.00
0165	Use of contrast during ultrasound study: add 6.00 ultrasound units	04.00		6.000	36.35 (31.89)	6.000	36.35 (31.89)			
5104	Ultrasound in pregnancy, multiple gestation, after twenty weeks: plus 30%									04.00
6100	In order to charge the full fee (600,00 magnetic resonance units) for an examination of a specific single anatomical region, it should be performed with the applicable radio frequency coil including T1 and T2 weighted images on at least two planes									04.00
6101	Where a limited series of a specific anatomical region is performed (except bone tumour), e.g a T2 weighted image of a bone for an occult stress fracture, not more than two-thirds (2/3) of the fee may be charged. Also applicable to all radiotherapy planning studies, per region									04.00
6102	All post-contrast studies (except bone tumour), including perfusion studies, to be charges at 50% of the fee									04.00
6106	Where a magnetic resonance angiography (MRA) of large vessels is performed as primary examination, 100% of the fee is applicable. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability									04.00
6107	Where a magnetic resonance angiography (MRA) of the vessels is performed additional to an examination of a particular region, 50% of the fee is applicable for the angiography. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability									04.00
6300	If a procedure lasts less than 30 minutes, only 50% of the machine fees for items 3536-3550 will be allowed (specify time of procedure on account)									04.00
6301	If a procedure is performed by a radiologist in a facility not owned by himself, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)									04.00
6302	When the procedure is performed by a non-radiologist, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)									04.00
6303	When a procedure is performed entirely by a non-radiologist in a facility owned by a radiologist, the radiologist owning the facility may charge 55% of the procedure units used. Modifier 6302 applies to the non radiologist performing the procedure									04.00
6305	When multiple catheterisation procedures are used (items 3557, 3559, 3560, 3562) and an angiogram investigation is performed at each level, the unit value of each such multiple procedure will be reduced by 20,00 radiological units for each procedure after the initial catheterisation. The first catheterisation is charged at 100% of the unit value									04.00

I.	Consultative Services																	
I.a	General Practitioner visits																	
I.b	Specialists tiered consultation structure																	
I.b.1	New and established patients: Consultations/visits by psychiatrists (22) only																	
Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology										
				RVU	Fee	RVU	Fee	RVU	Fee									
I.c	General practitioner and specialist services																	
0190	New and established patient: Consultation/visit of new or established patient of an average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0173-0175 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure							06.02										
0191	New and established patient: Consultation/visit of new or established patient of a moderately above average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0173-0175 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure							06.02										
0192	New and established patient: Consultation/visit of new or established patient of long duration and/or high complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0173-0175 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure							06.02										
0173	First hospital consultation/visit of an average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure)							06.02										
0174	First hospital consultation/visit of a moderately above average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure)							06.02										
0175	First hospital consultation/visit of long duration and/or high complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure)							06.02										
0109	Hospital follow-up visit to patient in ward or nursing facility - Refer to general rule G(a) for post-operative care) (may only be charged once per day) (not to be used with items 0111, 0145, 0146, 0147 or ICU items 1204-1214)							06.04										
0111	Paediatric hospital follow-up visits (excluding neonates) by paediatricians or paediatric cardiologists (may only be charged once per day) (not to be used with items 0109 or ICU items 1204-1214). For a healthy neonate please use item 0109 for a hospital follow-up visit							06.04										
0146	For an unscheduled emergency consultation/visit at the doctors' home or rooms, all hours: ADD only to the consultation/visit items 0190-0192, items 0161-0164 or items 0151-0153, as appropriate (refer to general rule B). Note: Only one of items 0145, 0146 or 0147 may be charged and not combinations thereof							06.05	+									
0147	For an unscheduled emergency consultation/visit away from the doctor's home or rooms, all hours: ADD only to the consultation/visit items 0190-0192, items 0173-0175, items 0161-0164, items 0166-0169 or items 0151-0153, as appropriate. Note: Only one of items 0145, 0146 or 0147 may be charged and not combinations thereof							06.05	+									
0149	After-hours bona fide emergency consultation/visit (21:00-6:00 daily): ADD 25% of the fee for the appropriate consultation/visit item (only to be used with items 0190-0192, items 0173-0175, items 0161-0164, items 0166-0169 or items 0151-0153) and reflect this as a separate item 0149. Note: The after-hour period applicable to this item is from Monday to Sunday 21:00-6:00							06.05										

Practice Type	0190	0191	0192	0173	0174	0175	0109	0111	0129	0145	0146	0147	0148	0149
Anaesthesiology	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)								

Cardiology	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)								
Cardiothoracic Surgery	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)								
General Medical Practice	172.60 (151.40)	172.60 (151.40)	172.60 (151.40)	172.60 (151.40)	172.60 (151.40)	172.60 (151.40)	154.00 (135.10)		154.00 (135.10)	61.60 (54.00)	82.10 (72.00)	143.70 (126.10)	-	-
Medicine (Specialist Physician)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)								
Neurosurgery	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)								
Nuclear Medicine	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)								
Obstetrics and Gynaecology	184.80 (162.10)	184.80 (162.10)	184.80 (162.10)	184.80 (162.10)	184.80 (162.10)	184.80 (162.10)								
Opthalmology	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)								
Orthopaedics	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)								
Otorhinolaryngology	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)								
Paediatric Cardiology	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)		231.00 (202.60)						
Paediatrics	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)		231.00 (202.60)						
Pathology (Anatomical)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)								
Pathology (Clinical)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)								
Plastic and Reconstructive Surgery	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)								
Pulmonology	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)	266.90 (234.10)								
Radiology	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)								
Specialists							154.00 (135.10)		154.00 (135.10)	61.60 (54.00)	82.10 (72.00)	143.70 (126.10)	-	-
Surgery	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)								
Urology	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)	174.50 (153.10)								

I.e	Pre-anaesthetic assessment									
Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology		
				RVU	Fee	RVU	Fee	RVU	Fee	
0151	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient (all hours). Problem focused history and clinical examination and straightforward decision making for minor problem. Typically occupies the doctor face-to-face with the patient for between 10 and 20 minutes	06.04				16.000	164.20 (144.00)	16.000	164.20 (144.00)	
0152	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient (all hours). Detailed history and clinical examination and straightforward decision making and counselling. Typically occupies the doctor face-to-face with the patient for between 20 and 35 minutes	06.04				16.000	164.20 (144.00)	16.000	164.20 (144.00)	
0153	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient or other consultative service. Consultation with detailed history, complete examination and moderate complex decision making and counselling. Typically occupies the doctor face-to-face for between 30 and 45 minutes	06.04				16.000	164.20 (144.00)	16.000	164.20 (144.00)	
I.f	**Prenatal visits and new born attendance**									
0107	New born attendance: Exclusive attendance to baby at Caesarean section, normal delivery or visit in the ward (once per patient) (items 0109, 0111, 0113, 0145, 0146 and/or 0147 may not be added to item 0107)	06.02		33.000	338.70 (297.10)	33.000	338.70 (297.10)			
	Item 0107 can be used once only for given confinement	04.00								
0113	New born attendance: Emergency attendance to newborn at all hours (once per patient) (items 0107, 0109, 0111, 0145, 0146 and/or 0147 may not be added to item 0113)	06.02		45.000	461.90 (405.20)	45.000	461.90 (405.20)			
I.g	**Consultative services: Miscellaneous**									
0130	Telephone consultation (all hours)							04.00		
0132	Consulting service e.g. writing of repeat scripts or requesting routine pre-authorisation without the physical presence of the patient (needs not be face-to-face contact) ("Consultation" via SMS or electronic media included)							04.00		
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							04.00		
0199	Completion of chronic medication forms by medical practitioners with or without the physical presence of the patient requested by or on behalf of a third party funder or its agent							04.00		

Practice Type	0130	0132	0133	0199
Anaesthesiology	123.20 (108.10)			
Cardiology	184.80 (162.10)			
Cardiothoracic Surgery	174.50 (153.10)			
General Medical Practice	123.20 (108.10)	51.30 (45.00)	92.40 (81.10)	220.00 (193.00)
Medicine (Specialist Physician)	184.80 (162.10)			
Neurology	184.80 (162.10)			
Neurosurgery	184.80 (162.10)			
Nuclear Medicine	184.80 (162.10)			
Obstetrics and Gynaecology	123.20 (108.10)			

Opthalmology		123.20 (108.10)							
Orthopaedics		123.20 (108.10)							
Otorhinolaryngology		123.20 (108.10)							
Paediatric Cardiology		184.80 (162.10)							
Paediatrics		184.80 (162.10)							
Pathology (Anatomical)		123.20 (108.10)							
Pathology (Clinical)		123.20 (108.10)							
Physical Medicine		184.80 (162.10)							
Plastic and Reconstructive Surgery		123.20 (108.10)							
Pulmonology		184.80 (162.10)							
Radiology		123.20 (108.10)							
Specialists			51.30 (45.00)		92.40 (81.10)		220.00 (193.00)		
Surgery		123.20 (108.10)							
Urology		123.20 (108.10)							
II.	**Medicine, material, supplies and use of own equipment**								
II.a	**Medicine codes**								
II.a.1	**Dispensing of medicine by licensed dispensing medical practitioners**								
0197	Licensed dispensing medical practitioners: Dispensing cost - R16.00 for medicine with a cost of R100, 00 or more (VAT inclusive), or 16% for medicine costing less than R100, 00 (VAT inclusive). Add to each Nappi code to provide for the dispensing cost.	06.02							
II.a.2	**Once-off administration of medicine used during a consultation**								
0198	Once-off administration of medicines: This item provides for medicines used at a consultation, viz, once off administration of medicine, special medicine used in treatment, or emergency dispensing. Charge for medicine used according to the Single Exit Price (SEP) PLUS R16,00 for medicine with a cost of R100,00 or more, or 16% for medicine costing less than R100,00 PLUS VAT on the 16%/R16,00. (Where applicable, VAT should be added to the 16%/R 16,00 only and not to the SEP, since the SEP is VAT inclusive). [According to Section 18(8) of the Medicines and Related Substances Act (Act 101 of 1965) compounding and dispensing does not refer to a medicine requiring preparation for a once-off administration to a patient during a consultation]. The appropriate Ethical Medicine Nappi code(s), selected from those codes commencing with 7, 8 or 9 (provided that it is not a reference code), should be added applicable to the medicine used. Please note: Refer to item 0201 for cost of material used in treatment.	06.02							
II.b	**Material codes**								
II.b.1	**Prosthesis and/or internal fixation**								
0200	Prosthesis and/or internal fixation: This item provides for a charge for prosthesis and/or internal fixation. Charge for prosthesis and/or internal fixation at cost price PLUS 26% (up to a maximum of R 26,00). (Where applicable, VAT should be added to the above). The appropriate Nappi code(s), where applicable, for the prosthesis and/or internal fixation used, must be provided.	06.02							

II.b.2	**Material used during a consultation**									
0201	Cost of material in treatment: This item provides for a charge for material used in treatment. Charge for material at cost price PLUS 26% (up to a maximum of R26,00). (Where applicable, VAT should be added to the above). The appropriate Surgical and Material Nappi code(s), selected from those codes commencing with 4, 5, 6, where applicable, for the material used, must be provided. Please note: Refer to item 0198 for once off administration of medicine.	06.02								
II.c	**Setting of sterile tray**									
0202	Setting of sterile tray: 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, as appropriate	05.06		10.000	63.60 (55.80)	10.000	63.60 (55.80)			
II.d	**Own equipment used in treatment**									
5930	Surgical laser apparatus: Hire fee for own equipment	04.00		109.000	692.90 (607.80)	109.000	692.90 (607.80)			
GENERAL MODIFIERS GOVERNING THIS SECTION										
0011	Emergency procedures: 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. (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)									06.04
0013	Endoscopic examinations done at operations: Where a related endoscopic examination is done at an operation by the operating surgeon or the attending anaesthesiologist, only 50% of the fee for the endoscopic examination may be charged									04.00
0014	Operations previously performed by other surgeons: Where an operation is performed which has been previously performed by another surgeon, e.g. a revision or repeat operation, the fee shall be calculated according to the tariff for the full operation									04.00
MODIFIERS GOVERNING SECTION 1										
0015	Intravenous infusions: Where intravenous infusions (including blood and blood cellular products) are administered as part of the after-treatment after the operation or confinement, no extra fees shall be charged as this is included in the global operative or maternity fees. Should the practitioner doing the operation or attending to the maternity case prefer to ask another practitioner to perform post-operative or post-confinement intravenous infusions, then the practitioner himself (and not the patient) shall be responsible for remunerating such practitioner for the infusions									04.00
1	**General**									
1.1	**Injections, Infusions and Inhalation Sedation Treatment**									
Code	**Description**	**Ver**	**Add**	**Specialists**		**General Practitioners / non-designated Specialists**		**Anaesthesiology**		
				RVU	**Fee**	**RVU**	**Fee**	**RVU**	**Fee**	
0203	Inhalation sedation: Use of analgesic nitrous oxide for alcohol and other withdrawal states: First quarter-hour or part thereof	04.00		6.000	38.10 (33.40)	6.000	38.10 (33.40)			
0204	Inhalation sedation: Per additional quarter-hour or part thereof	04.00		3.000	19.10 (16.80)	3.000	19.10 (16.80)			
0205	Intravenous treatment: Intravenous infusions (cut-down or push-in) (patients under three years): Cut-down and/or insertion of cannula - chargeable once per 24 hours	04.00		12.000	76.30 (66.90)	12.000	76.30 (66.90)			

0206	Intravenous treatment: Intravenous infusions (push-in) (patients over three years): Insertion of cannula - chargeable once per 24 hours	04.00		6.000	38.10 (33.40)	6.000	38.10 (33.40)		
0207	Intravenous treatment: Intravenous infusions (cut-down) (patients over three years): Cut-down and insertion of cannula - chargeable once per 24 hours	04.00		8.000	50.90 (44.60)	8.000	50.90 (44.60)		
0208	Venesection: Therapeutic venesection (Not to be used when blood is drawn for the purpose of laboratory investigations)	04.00		6.000	38.10 (33.40)	6.000	38.10 (33.40)		
0210	Collection of blood specimen(s) by medical practitioner for pathology examination, per venesection (not to be used by pathologists)	04.00		3.250	20.70 (18.20)	3.250	20.70 (18.20)		
	Note: HOW TO CHARGE FOR INTRAVENOUS INFUSIONS: Practitioners are entitled to charge according to the appropriate item whenever they personally insert the cannula (but may only charge for this service once every 24 hours). For managing the infusion as such, e.g. checking it when visiting the patient or prescribing the substance, no fee may be charged since this service is regarded as part of the services the doctor renders during consultations (not applicable to item 0205)	04.00							

MODIFIERS GOVERNING THE ADMINISTRATION OF ANAESTHETICS FOR ALL PROCEDURES AND OPERATIONS

0020	Conscious sedation: Any case that is conducted outside of a hospital theatre shall be coded with the relevant procedure code. To identify these cases, the above modifier should be used to indicate to the Fund that there will be no hospital/theatre account.	06.06
0021	Determination of anaesthetic fees: Anaesthetic fees are determined by obtaining the sum of the basic anaesthetic units (allocated to each procedure that might be performed under anaesthetic as indicated in the "Anaesthetic Performed" column) plus the time units (calculated according to the formula in Modifier 0023) and the appropriate modifers (see Modifiers 0037-0044). In cases of operative procedures on the musculoskeletal system, open fractures and open reduction of fractures or dislocations add units as laid down by Modifiers 5441 to 5448	06.04
0023	The basic anaesthetic units are laid down in the tariff and are reflected in the anaesthetic column. These basic anaesthetic units reflect the additional anaesthetic risk, the technical skill required of the anaesthesiologist/anaesthetist and the scope of the surgical procedure, but exclude the value of the actual time spent administering the anaesthetic. The time units (indicated by "T") will be added to the listed basic anaesthetic units in all cases on the following basis: Anaesthetic time: The remuneration for anaesthetic time shall be per 15 minute period or part thereof, calculated from the commencement of the anaesthetic, i.e. 2,00 anaesthetic units per 15 minute period or part thereof, provided that should the duration of the anaesthetic be longer than one (1) hour the number of units shall, after one (1) hour, be 3,00 anaesthetic units per 15 minute period or part thereof.	06.05
0024	Pre-operative assessments not followed by procedures: If a pre-operative assessment of a patient by the anaesthesiologist/anaesthetist is not followed by an operation, it will be regarded as a visit at hospital or nursing home and the appropriate hospital visit item should be charged.	06.05
0025	Calculation of anaesthetic time: Anaesthetic time is calculated from the time the anaesthesiologist/anaesthetist begins to prepare the patient for the induction of anaesthesia in the operating theatre or in a similar equivalent area and ends when the anaesthesiologist/anaesthetist is no longer required to give his/her personal professional attention to the patient, i.e. when the patient may, with reasonable safety, be placed under the customary post-operative supervision. Where prolonged personal professional attention is necessary for the well-being and safety of such patient, the necessary time will be valued on the same basis as indicated above for the anaesthetic time. The anaesthesiologist/anaesthetist must show on his/her account the exact anaesthetic time, including the supervision time spent with the patient.	06.05
0027	More than one procedure under the same anaesthetic: Where more than one operation is performed under the same anaesthetic, the basic anaesthetic units will be that of the major operation with the highest number of units	06.04
0028	Indicator for use of low flow anaesthetic technique less than 1litre/minute: Fresh gas flow of less than 1 litre/minute	06.06
0029	Assistant anaesthesiologists: When rendered necessary by the scope of the anaesthetic, an assistant anaesthesiologist may be employed. The remuneration of the assistant anaesthesiologist shall be calculated on the same basis as in the case where a general practitioner administers the anaesthetic	06.04
0030	Indicator for use of low flow anaesthetic technique 1-2 litre/minute: Fresh gas flow of 1 to 2 litre/minute	06.06

0031	Intravenous drips and transfusions: Treatment with intravenous drips and transfusions is considered part of the normal treatment in administering an anaesthetic. No additional fees may be charged for such services when rendered either prior to, or during actual theatre or operating time								06.04
0032	Patients in prone position: Anaesthesia administered to patients in the prone position shall have a minimum of 4,00 basic anaesthetic units. When the basic anaesthetic units for the procedure is 3, 00, one extra anaesthetic unit should be added. If the basic anaesthetic units for the procedure is 4,00 or more, no extra units should be added								06.04
0033	Participating in general care of patients: When an anaesthesiologist/anaesthetist is required to participate in the general care of a patient during a surgical procedure, but does not administer the anaesthetic, such services may be remunerated at full anaesthetic rate, subject to the provisos of modifier 0035: Anaesthetic administered by an anaesthesiologist/anaesthetist. and modifier 0036: Anaesthetic administered by general practitioners.								06.05
0034	Head and neck procedures: All anaesthetics administered for diagnostic, surgical or X-ray procedures on the head and neck shall have a minimum of 4,00 basic anaesthetic units. When the basic anaesthetic units for the procedure is 3,00, one extra anaesthetic unit should be added. If the basic anaesthetic units for the procedure is 4,00 or more, no extra units should be added								06.04
0035	Anaesthetic administered by an anaesthesiologist/anaesthetist: No anaesthetic administered shall have a total value of less than 7,00 anaesthetic units (basic units, time units plus appropriate modifiers).								06.05
0036	Anaesthetic administered by general practitioners: The units (basic units plus time plus the appropriate modifiers) used to calculate the fee for an anaesthetic administered by a general practitioner lasting one hour or less shall be the same as that for an anaesthesiologist. For anaesthetic lasting more than one hour, the units used to calculate the fee for an anaesthetic administered by a general practitioner will be 4/5 (80%) of the total number of units (basic units plus time [refer to modifier 0023] plus the appropriate modifiers) applicable to an anaesthesiologist. Please note that the 4/5 (80%) principle will be applied to all anaesthetics administered by general practitioners with the proviso that no anaesthetic with a total number of units higher than 11.00 will be reduced to less than 11,00 units in total. The monetary value of the unit is the same for both an anaesthesiologist/anaesthetist.								06.05
0037	Body hypothermia: Utilisation of total body hypothermia: Add 3,00 anaesthetic units	06.04						3.000	119.69 (104.99)
0038	Peri-operative blood salvage: Add 4,00 anaesthetic units for intra-operative blood salvage and 4,00 anaesthetic units for post-operative blood salvage								06.04
0039	Control of blood pressure: Deliberate control of the blood pressure: All cases up to one hour: Add 3,00 anaesthetic units, thereafter add 1,00 (one) additional anaesthetic unit per quarter hour or part thereof								06.04
0041	Hyperbaric pressurisation: Utilisation of hyperbaric pressurisation: Add 3,00 anaesthetic units	06.04						3.000	119.69 (104.99)
0042	Extracorporeal circulation: Utilisation of extracorporeal circulation: Add 3,00 anaesthetic units	06.04						3.000	119.69 (104.99)
0043	Patients under one year of age: For all cases where the patient is under one year of age – 3,00 anaesthetic units to be added	06.04						3.000	119.69 (104.99)
0044	Neonates (i.e up to and including 28 days after birth): 3,00 anaesthetic units to be added to the basic anaesthetic units for the particular procedure. This modifier is charged in addition to Modifier 0043: Cases under one year of age	06.04						3.000	119.69 (104.99)
0100	Intra-aortic balloon pump: Where an anaesthesiologist would be responsible for operating an intra-aortic balloon pump, a fee of 75,00 clinical procedure units is applicable.								06.06
	Modifiers 5441 to 5448 Modification of the anaesthetic fee in cases of operative procedures on the musculo-skeletal system, open fractures and open reduction of fractures and dislocations is governed by adding units indicated by modifiers 5441 to 5448. (The letter "M" is annotated next to the number of units of the appropriate items, for facilitating identification of the relevant items)								06.04
5441	Add one (1,00) anaesthetic unit, except where the procedure refers to the bones named in Modifiers 5442 to 5448	06.04						1.000	39.90 (35.00)
5442	Shoulder, scapula, clavicle, humerus, elbow joint, upper 1/3 tibia, knee joint, patella, mandible and tempero-mandibular joint: Add two (2,00) anaesthetic units	06.04						2.000	79.79 (69.99)

5443	Maxillary and orbital bones: Add three (3,00) anaesthetic units	06.04						3.000	119.69 (104.99)
5444	Shaft of femur: Add four (4,00) anaesthetic units	06.04						4.000	159.58 (139.98)
5445	Spine (except coccyx), pelvis, hip, neck of femur: Add five (5,00) anaesthetic units	06.04						5.000	199.48 (174.98)
5448	Sternum and/or ribs and musculo-skeletal procedures which involve an intra-thoracic approach: Add eight (8,00) anaesthetic units	06.04						8.000	319.16 (279.96)
POST-OPERATIVE ALLEVIATION OF PAIN									
0045	Post-operative alleviation of pain: (a) When a regional or nerve block procedure is performed, the appropriate procedure item to patient in ward or nursing facility, can be charged, provided that it is not the primary anaesthetic technique (b) When a second medical practitioner has administered the regional or nerve block for post-operative alleviation of pain, it shall be charged according to the particular procedure for instituting therapy. Revisits shall be charged according to the appropriate hospital follow-up visit to patient in ward or nursing facility. (c) None of the above is applicable for routine post-operative pain management i.e. intramuscular, intravenous or subcutaneous administration of opiates or NSAID (non-steroidal anti-inflammatory drug)								06.04
2	**Integumentary System**								
2.1	**Burns**								
0351	Major Burns: Resuscitation (including supervision and intravenous therapy - first 48 hours)	04.00		276.000	1754.50 (1539.00)	220.800	1403.60 (1231.20)	5.000	199.50 (175.00)
3	**Musculo-skeletal System**								
MODIFIERS GOVERNING ORTHOPAEDIC OPERATIONS AND ANAESTHETIC FEES FOR ORTHOPAEDIC OPERATIONS									
0047	A fracture NOT requiring reduction shall be charged on a fee per service basis								04.00
Code	**Description**	**Ver**	**Add**	**Specialists**		**General Practitioners / non-designated Specialists**		**Anaesthesiology**	
				RVU	**Fee**	**RVU**	**Fee**	**RVU**	**Fee**
0048	Where in the treatment of a fracture or dislocation, an initial closed reduction is followed within one month by further closed reductions under general anaesthesia, the fee for such subsequent reductions will be 27,00 clinical procedure units (not including after-care)	04.00		27.000	171.64 (150.56)	27.000	171.64 (150.56)		
0049	Except where otherwise specified, in cases of compound fractures, 77,00 clinical procedure units (specialists) and 77,00 clinical procedure units (general practitioners) are to be added to the units for the fractures including debridement	04.11		77.000	489.49 (429.38)	77.000	489.49 (429.38)		

0050	In cases of a compound fracture where a debridement is followed by internal fixation (excluding fixation with Kirschner wires, as well as fractures of hands and feet), the full amount according to either Modifier 0049: Cases of compound fractures, or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, may be added to the fee for the procedure involved, plus half of the amount according to the second modifier (either Modifier 0049: Cases of compound fractures or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, as applicable)	04.00		115.50 0	734.23 (644.06)	115.50 0	734.23 (644.06)		
0051	Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting: Specialists add 77,00 clinical procedure units. General practitioners add 77,00 clinical procedure units	04.11		77.000	489.49 (429.38)	77.000	489.49 (429.38)		
0053	Fracture requiring percutaneous internal fixation [insertion and removal of fixatives (wires) in respect of fingers and toes included]: Specialists and general practitioners add 32,00 clinical procedure units	04.00		32.000	203.42 (178.44)	32.000	203.42 (178.44)		
3.1	**Amputations**								
3.1.1	**Amputations: Specific Amputations**								
0682	Amputation: Fore-quarter amputation	04.00		294.00 0	1869.00 (1639.50)	235.20 0	1495.20 (1311.60)	9.000	359.10 (315.00)
0683	Amputation: Through shoulder	04.00		148.00 0	940.80 (825.30)	120.00 0	762.80 (669.10)	5.000	199.50 (175.00)
0685	Amputation: Upper arm or fore-arm	04.00		116.00 0	737.40 (646.80)	116.00 0	737.40 (646.80)	3.000	119.70 (105.00)
0687	Partial amputation of the hand: One ray	04.00		102.00 0	648.40 (568.80)	102.00 0	648.40 (568.80)	3.000	119.70 (105.00)
0691	Amputation: Whole or part of finger	06.04		116.80 0	742.50 (651.30)	116.80 0	742.50 (651.30)	3.000	119.70 (105.00)
0693	Hindquarter amputation	04.00		420.00 0	2669.90 (2342.00)	336.00 0	2136.00 (1873.70)	6.000	239.40 (210.00)
0695	Amputation: Through hip joint region	04.00		192.00 0	1220.50 (1070.60)	153.60 0	976.40 (856.50)	6.000	239.40 (210.00)
0697	Amputation: Through thigh	04.00		205.00 0	1303.20 (1143.20)	164.00 0	1042.50 (914.50)	6.000	239.40 (210.00)
0699	Amputation: Below knee, through knee or Syme	04.00		194.00 0	1233.30 (1081.80)	155.20 0	986.60 (865.40)	5.000	199.50 (175.00)
4	**Respiratory System**								
4.1	**Pleura**								
1141	Insertion of intercostal catheter (under water drainage)	04.00		50.000	317.90 (278.90)	50.000	317.90 (278.90)	6.000	239.40 (210.00)
1142	Intra-pleural block	04.00		36.000	228.90 (200.80)	36.000	228.90 (200.80)	36.000	228.90 (200.80)
1143	Paracentesis chest: Diagnostic	04.00		8.000	50.90 (44.60)	8.000	50.90 (44.60)	3.000	119.70 (105.00)
1145	Paracentesis chest: Therapeutic	04.00		13.000	82.60 (72.50)	13.000	82.60 (72.50)	3.000	119.70 (105.00)

1147	Pneumothorax: Induction (diagnostic)	04.00		25.000	158.90 (139.40)	25.000	158.90 (139.40)		
1149	Pleurectomy	04.00		250.000	1589.30 (1394.10)	200.000	1271.40 (1115.30)	11.000	438.80 (384.90)
4.2	**Intensive care**								
RULES GOVERNING THIS SECTION									
Q.	Intensive care/High Care: Units in respect of items 1204 to 1210 (Categories 1 to 3) EXCLUDE the following: (a) Anaesthetic and/or surgical fees for any condition or procedure, as well as a first consultation/visit, which is, regarded as the assessment of the patient, while the daily intensive care/high care fee covers the daily care in the intensive/high care unit. (b) Cost of any drugs and/or materials. (c) Any other cost which may be incurred before, during or after the consultation/visit and/or the therapy. (d) Blood gases and chemistry tests, including the arterial puncture to obtain the specimen. (e) Procedural items 1202 and 1212 to 1221. but INCLUDE the following: (f) Performing and interpretation of a resting ECG. (g) Interpretation of chemistry tests and x-rays. (h) Intravenous treatment (items 0206 and 0207), except intravenous infusion in patients under the age of three years (item 0205) that does not form a part of the daily ICU/High Care fee and may be charged for separately on a daily basis (fee includes the introduction of the cannula as well as the daily management)								06.05
R.	Multiple organ failure: Units for items 1208, 1209 and 1210 (Category 3: Cases with multiple organ failure) include resuscitation (i.e. item 1211: Cardio-respiratory resuscitation)								04.00
S.	Ventilation: Units for items 1212, 1213 and 1214 (ventilation) include the following: (a) Measurement of minute volume, vital capacity, time- and vital capacity studies. (b) Testing and connecting the machine. (c) Putting patient on machine: setting machine, synchronising patient with machine. (d) Instruction to nursing staff. (e) All subsequent visits for 24 hours.								04.00
T.	Ventilation (items 1212 to 1214) does not form a part of normal post-operative care, but may not be added to item 1204: Catogory 1: Cases requiring intensive monitoring								04.00
4.2.1	**Intensive care: (in intensive care or high care unit): Respiratory, cardiac, general: Neonatal procedures**								
1202	Insertion of central venous catheter via peripheral vein in neonates	04.00		40.000	254.30 (223.10)	40.000	254.30 (223.10)	40.000	254.30 (223.10)
4.2.2	**Intensive care: (in intensive care or high care unit): Respiratory, cardiac, general: Tariff items for intensive care**								
1204	Intensive care: Category 1: Cases requiring intensive monitoring (to include cases where physiological instability is anticipated e.g. diabetic pre-coma, asthma, gastro-intestinal haemorrhage, etc.): Per day	04.00		30.000	190.70 (167.30)	30.000	190.70 (167.30)	30.000	190.70 (167.30)
1205	Intensive care: Category 2: Cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc. Ventilation may or may not be part of the active system support): First day	04.00		100.000	635.70 (557.60)	100.000	635.70 (557.60)	100.000	635.70 (557.60)
1206	Intensive care: Category 2: Cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc. Ventilation may or may not be part of the active system support): Subsequent days, per day	04.00		50.000	317.90 (278.90)	50.000	317.90 (278.90)	50.000	317.90 (278.90)
1207	Intensive care: Category 2: Cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc. Ventilation may or may not be part of the active system support): After two weeks, per day	04.00		30.000	190.70 (167.30)	30.000	190.70 (167.30)	30.000	190.70 (167.30)
	Please Note: The principal practitioner may charge items 1205 - 1207, other participating practitioners must charge the consultation item, e.g. item 0109	04.00							
1208	Intensive care: Category 3: Cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention: First day (primary practitioner)	04.00		137.000	870.90 (763.90)	120.000	762.80 (669.10)	137.000	870.90 (763.90)
1209	Intensive care: Category 3: Cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention: First day (per involved practitioner)	04.00		58.000	368.70 (323.40)	58.000	368.70 (323.40)	58.000	368.70 (323.40)

1210	Intensive care: Category 3: Cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention: Subsequent days (per involved practitioner)	04.00		50.000	317.90 (278.90)	50.000	317.90 (278.90)	50.000	317.90 (278.90)
4.2.3	**Intensive care: (in intensive care or high care unit): Respiratory, cardiac, general: Procedures**								
1211	Cardio-respiratory resuscitation: Prolonged attendance in cases of emergency (not necessarily in ICU) - 50,00 clinical procedure units per half hour or part thereof for the first hour per practitioner, thereafter 25,00 clinical procedure units per half hour up to a maximum of 150,00 clinical procedure units per practitioner. Resuscitation fee includes all necessary additional procedures e.g. infusion, intubation, etc.	04.00							
1212	Ventilation: First day	04.00		75.000	476.80 (418.20)	75.000	476.80 (418.20)	75.000	476.80 (418.20)
1213	Ventilation: Subsequent days, per day	04.00		50.000	317.90 (278.90)	50.000	317.90 (278.90)	50.000	317.90 (278.90)
1215	Insertion of arterial pressure cannula	04.00		25.000	158.90 (139.40)	25.000	158.90 (139.40)	25.000	158.90 (139.40)
1216	Insertion of Swan Ganz catheter for haemodynamics monitoring	04.11		50.000	317.90 (278.90)	50.000	317.90 (278.90)	50.000	317.90 (278.90)
1217	Insertion of central venous line via peripheral vein	04.00		10.000	63.60 (55.80)	10.000	63.60 (55.80)	10.000	63.60 (55.80)
1218	Insertion of central venous line via subclavian or jugular veins	04.00		25.000	158.90 (139.40)	25.000	158.90 (139.40)	25.000	158.90 (139.40)
1220	Patient-controlled analgesic pump: Hire fee: Per 24 hours (Cassette to be charged for according to item 0201 per patient)	04.00		30.000	190.70 (167.30)	30.000	190.70 (167.30)	30.000	190.70 (167.30)
1221	Professional fee for managing a patient-controlled analgesic pump: First 24 hours (for subsequent days charged the appropriate hospital follow-up consultation/visit code)	04.00		30.000	190.70 (167.30)	30.000	190.70 (167.30)	30.000	190.70 (167.30)
4.3	**Hyperbaric Oxygen Therapy**								
	Internationally recognized scientific indications for Hyperbaric Oxygen Therapy: a. Arterial gas embolism (traumatic or iatrogenic). b. Decompression sickness ('the bends') c. Carbon monoxide poisoning d. Gas gangrene e. Crush injuries, compartment syndromes or acute traumatic ischaemias. f. Necrotising soft tissue infections (e.g. necrotising fasciitis) g. Acute bloodloss anaemia (transfusion is contraindicated - e.g. Jehovah's Witnesses or haemolytic anaemia).								04.00
1223	Mediastinoscopy	04.00		95.000	603.90 (529.70)	95.000	603.90 (529.70)	5.000	199.50 (175.00)
1224	Mediastinotomy	04.00		115.000	731.10 (641.30)	115.000	731.10 (641.30)	11.000	438.80 (384.90)

5	**Cardiovascular System**								
MODIFIER GOVERNING FEES FOR AN ANAESTHESIOLOGIST OPERATING INTRA-AORTIC BALLOON PUMP									
5.1	**Cardiovascular system: General**								
1227	Prolonged neonatal resuscitation	04.00		20.000	127.10 (111.50)	20.000	127.10 (111.50)	20.000	127.10 (111.50)
	Where ECG is done by a general practitioner but interpreted by a physician, the general practitioner is entitled to a consultation fee, plus half of fee determined for ECG	04.00							
1228	General Practitioner's fee for the taking of an ECG only: Without effort: ½ (item 1232)	04.00				4.500	28.60 (25.10)		
1229	General Practitioner's fee for the taking of an ECG only: Without and with effort: ½ (item 1233)	04.00				6.500	41.30 (36.20)		
	Note: Items 1228 and 1229 deal only with the fees for taking of the ECG, the consultation fee must still be added	04.00							
1230	Physician's fee for interpreting an ECG: Without effort	04.00		6.000	38.10 (33.40)				
1231	Physician's fee for interpreting an ECG: With and without effort	06.04		10.000	63.60 (55.80)				
	A specialist physician is entitled to the fees specified in item 1230 and 1231 for interpretation of an ECG tracing referred for interpretation. This applies also to a paediatrician when an ECG of a child is referred to him for interpretation	04.00							
1232	Electrocardiogram: Without effort	04.00		9.000	57.20 (50.20)	9.000	57.20 (50.20)		
1233	Electrocardiogram: With and without effort	06.04		13.000	82.60 (72.50)	13.000	82.60 (72.50)		
6.1	**Liver**								
1749	Hemi-hepatectomy: Right	04.00		564.00 0	3585.30 (3145.00)	451.20 0	2868.30 (2516.10)	9.000	359.10 (315.00)
1751	Hemi-hepatectomy: Left	04.00		521.10 0	3312.60 (2905.80)	416.88 0	2650.10 (2324.60)	9.000	359.10 (315.00)
1752	Extended right or left hepatectomy	04.00		570.90 0	3629.20 (3183.50)	456.72 0	2903.40 (2546.80)	9.000	359.10 (315.00)
1753	Partial or segmental hepatectomy	04.00		378.00 0	2402.90 (2107.80)	302.40 0	1922.40 (1686.30)	9.000	359.10 (315.00)
1757	Suture of liver wound or injury	04.00		214.20 0	1361.70 (1194.50)	171.36 0	1089.30 (955.50)	9.000	359.10 (315.00)
6.2	**Peritoneal cavity**								
1797	Pneumo-peritoneum: First	04.00		13.000	82.60 (72.50)	13.000	82.60 (72.50)	4.000	159.60 (140.00)
1799	Pneumo-peritoneum: Repeat	04.00		6.000	38.10 (33.40)	6.000	38.10 (33.40)	4.000	159.60 (140.00)

1800	Peritoneal lavage	04.00		20.000	127.10 (111.50)	20.000	127.10 (111.50)		
1801	Diagnostic paracentesis: Abdomen	04.00		8.000	50.90 (44.60)	8.000	50.90 (44.60)		
1803	Therapeutic paracentesis: Abdomen	04.00		13.000	82.60 (72.50)	13.000	82.60 (72.50)		
1807	ADD to open procedure where procedure was performed through a laparoscope (for anaesthetic refer to modifier 0027)	04.00	+	45.000	286.10 (251.00)	45.000	286.10 (251.00)	5.000	199.50 (175.00)
1809	Laparotomy	04.00		196.00 0	1246.00 (1093.00)	156.80 0	996.80 (874.40)	4.000	159.60 (140.00)
1811	Suture of burst abdomen	04.00		188.30 0	1197.00 (1050.00)	150.64 0	957.60 (840.00)	7.000	279.30 (245.00)
1812	Laparotomy for control of surgical haemorrhage	04.00		105.00 0	667.50 (585.50)	105.00 0	667.50 (585.50)	9.000	359.10 (315.00)
7.	**Skull procedures**								
2859	Repair of depressed fracture of skull: Without brain laceration: Major	04.00		200.00 0	1271.40 (1115.30)	160.00 0	1017.10 (892.20)	8.000	319.20 (280.00)
2860	Repair of depressed fracture of skull: Without brain laceration: Small	04.00		170.00 0	1080.70 (948.00)	136.00 0	864.60 (758.40)	8.000	319.20 (280.00)
2861	Repair of depressed fracture of skull: With brain lacerations: Small	04.00		200.00 0	1271.40 (1115.30)	160.00 0	1017.10 (892.20)	8.000	319.20 (280.00)
2862	Repair of depressed fracture of skull: With brain lacerations: Major	04.00		375.00 0	2383.90 (2091.10)	300.00 0	1907.10 (1672.90)	8.000	319.20 (280.00)
7.1	**Shunt procedures**								
2871	Ventriculo-caval shunt	04.00		280.00 0	1780.00 (1561.40)	224.00 0	1424.00 (1249.10)	11.000	438.80 (384.90)
7.2	**Posterior fossa surgery: Supratentorial procedures**								
2899	Craniectomy for extra-dural haematoma or empyema	04.00		375.00 0	2383.90 (2091.10)	300.00 0	1907.10 (1672.90)	11.000	438.80 (384.90)
7.3	**Craniotomy for**								
2909	Craniotomy for CSF-leaks	04.00		450.00 0	2860.70 (2509.40)	360.00 0	2288.50 (2007.50)	11.000	438.80 (384.90)
8.1	**Retina**								
3037	Surgical treatment of retinal detachment including vitreous replacement but excluding vitrectomy	04.00		306.90 0	1951.00 (1711.40)	245.52 0	1560.80 (1369.10)	6.000	239.40 (210.00)
3039	Prophylaxis and treatment of retina and choroid by cryotherapy and/or diathermy and/or photocoagulation and/or laser per eye	04.00		105.00 0	667.50 (585.50)	105.00 0	667.50 (585.50)	6.000	239.40 (210.00)
8.2	**Intra-ocular foreign body**								
3071	Intra-ocular foreign body: Anterior to Iris	04.00		127.00 0	807.30 (708.20)	120.00 0	762.80 (669.10)	4.000	159.60 (140.00)

3073	Intra-ocular foreign body: Posterior to Iris (including prophylactic thermal treatment to retina)	04.00		210.00 0	1335.00 (1171.10)	168.00 0	1068.00 (936.80)	6.000	239.40 (210.00)
8.3	**Globe**								
3080	Examination of eyes under general anaesthetic where no surgery is done	04.00		80.000	508.60 (446.10)	80.000	508.60 (446.10)	4.000	159.60 (140.00)
3081	Treatment of minor perforating injury	04.00		161.60 0	1027.30 (901.10)	129.28 0	821.80 (720.90)	6.000	239.40 (210.00)
3083	Treatment of major perforating injury	04.00		267.50 0	1700.50 (1491.70)	214.00 0	1360.40 (1193.30)	6.000	239.40 (210.00)
8.4	**Lids: Reconstruction of eyelid**								
3185	Staged procedure for partial or total loss of eyelid: First stage	04.00		259.00 0	1646.50 (1444.30)	207.20 0	1317.20 (1155.40)	4.000	159.60 (140.00)
3187	Staged procedure for partial or total loss of eyelid: Subsequent stage	04.00		206.00 0	1309.50 (1148.70)	164.80 0	1047.60 (918.90)	4.000	159.60 (140.00)
3189	Full thickness eyelid laceration for tumour or injury: Direct repair	04.00		136.50 0	867.70 (761.10)	120.00 0	762.80 (669.10)	4.000	159.60 (140.00)
SPECIAL MODIFIER: SECTION ON PHYSICAL TREATMENT									
9	**Radiology**								
	Please note: The calculated amounts in this section (except for sections 19.9 and 19.11) are calculated according to the radiology unit values								04.00
RULES GOVERNING THE SECTION RADIOLOGY									
Y.	Except where otherwise indicated, radiologists are entitled to charge for contrast material used								04.00
Z.	No fee is subject to more than one reduction								04.00
GG.	Capturing and recording of examinations: Images from all radiological, ultrasound and magnetic resonance imaging procedures must be captured during every examination and a permanent record generated by means of film, paper, or magnetic media. A report of the examination, including the findings and diagnostic comment, must be written and stored for five years								04.00
RR.	The radiology section in this price list is not for use by registered specialist radiology practices (Pr No "038") or nuclear medicine practices (Pr No "025"), but only for use by other specialist practices or general practitioners. A separate radiology schedule is for the exclusive use of registered specialist radiology practices (Pr No "038") and nuclear medicine practices (Pr No "025").								04.00
MODIFIERS GOVERNING THE SECTION									
0002	Written report on X-rays: The lowest level code for a new patient office (consulting rooms) visit, is applicable only where a radiologist is requested to give a written report on X-rays taken elsewhere and submitted to him. The above mentioned item and the lowest level initial hospital visit code, as appropriate are not to be used for routine reporting of X-rays taken elsewhere								04.00
0080	Multiple examinations: Full Fee								04.00
0081	Repeat examinations: No reduction								04.00
0082	"+" Means that this item is complementary to a preceding item and is therefore not subject to reduction								04.00
0083	A reduction of 33,33% (1/3) in the fee will apply to radiological examinations as indicated in section 19: Radiology where hospital equipment is used								04.00
0084	Film costs: In the case of radiological items where films are used, practitioners should adjust the fee upwards or downwards in accordance with changes in the price of films in comparison with November 1979; the calculation must be done on the basis that film costs comprise 10% of the monetary value of the unit (This information is obtainable from the Radiological Society of SA)								04.00

9.1	Skeleton									
9.1.1	Skeleton: Limbs									
Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology		
				RVU	Fee	RVU	Fee	RVU	Fee	
6500	Hand	04.00				7.700	69.30 (60.80)			
6504	Radius and ulna	04.00				7.700	69.30 (60.80)			
6505	Elbow	04.00				7.700	69.30 (60.80)			
6506	Humerus	04.00				7.700	69.30 (60.80)			
6507	Shoulder	04.00				7.700	69.30 (60.80)			
6514	Tibia and fibula	04.00				7.700	69.30 (60.80)			
6515	Knee	04.00				7.700	69.30 (60.80)			
6517	Femur	04.00				7.700	69.30 (60.80)			
6518	Hip	04.00				7.700	69.30 (60.80)			
9.2	Abdomen									
3479	Acute abdomen or equivalent studies	04.00				15.700	141.40 (124.00)			

9.3	**Vascular studies**									
	The following rules are applicable to Section 19.8 (Vascular studies) and Section 19.14 (Interventional Radiological Procedures): a. The machine fee (items 3536 to 3550 includes the cost of the following: i. All runs (runs may not be billed for separately). ii. All film costs (modifier 0084 is not applicable). iii All fluoroscopy (item 3601 does not apply). iv All minor consumables (defined as any item other than catheters, guidewires, introducer sets, specialised catheters, balloon catheters, stents, embolic agents, drugs and contrast media). b. The machine fee (items 3536 to 3550) may only be billed for as a once off fee per case per day by the owner of the equipment and is only applicable to radiology practices. c. If a procedure is performed by a non-radiologist together with a radiologist as a team, in a facility owned by the radiologist, each member of the team will fee at their respective full rates as per modifiers and the applicable items. d. If a procedure is performed by a non-radiologists and a radiologist as a team, in a facility not owned by the radiologist, modifiers 6301 and 6302 applies. Please note : Modifier 0083 is not applicable to section 19.8 (Vascular Studies) and section 19.14 (Interventional Radiological Procedures)									04.00
MODIFIER GOVERNING VASCULAR STUDIES										
0086	Vascular groups: "Film series" and "Introduction of Contrast Media" are complementary and together constitute a single examination: neither fee is therefore subject to increase in terms of Modifier 0080: Multiple examinations									04.00
6300	If a procedure lasts less than 30 minutes, only 50% of the machine fees for items 3536-3550 will be allowed (specify time of procedure on account)									04.00
6301	If a procedure is performed by a radiologist in a facility not owned by himself, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)									04.00
6302	When the procedure is performed by a non-radiologist, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)									04.00
6303	When a procedure is performed entirely by a non-radiologist in a facility owned by a radiologist, the radiologist owning the facility may charge 55% of the procedure units used. Modifier 6302 applies to the non radiologist performing the procedure									04.00
6305	When multiple catheterisation procedures are used (items 3557, 3559, 3560, 3562) and an angiogram investigation is performed at each level, the unit value of each such multiple procedure will be reduced by 20,00 radiological units for each procedure after the initial catheterisation. The first catheterisation is charged at 100% of the unit value									04.00
9.3.1	**Vascular studies: Film Series**									
	Note: In the case of selective catheterisation of a branch of the aorta, the fee for catheterisation of the aorta is not added.									04.00
3536	Dedicated angiography suite: Analogue monoplane unit. Once off charge per patient by owner of equipment	04.00								
3537	Dedicated angiography suite: Digital monoplane unit. Once off charge per patient by owner of equipment	04.00								
3538	Analogue monoplane table with DSA attachment	04.00								
3539	Dedicated angiography suite: Digital bi-plane unit. Once off charge per patient by owner of equipment	04.00								
3540	Radiography fee for coronary catheterisation laboratory, per radiographer, per half hour or part thereof	04.00								
3545	Venography: Per limb	04.00				16.500	148.60 (130.40)			
3548	Analogue monoplane screening table	04.00								
3550	Digital monoplane screening table	04.00								

3557	Catheterisation aorta or vena cava, any level, any route, with aortogram/cavogram	04.00				48.600	437.60 (383.90)	4.000	159.60 (140.00)
3558	Translumbar aortic puncture, with full study	04.00				69.600	626.70 (549.70)	5.000	199.50 (175.00)
3559	Selective first order catheterisation, arterial or venous, with angiogram/venogram	04.00				57.000	513.30 (450.30)	4.000	159.60 (140.00)
3560	Selective second order catheterisation, arterial or venous, with angiogram/ venogram	06.04				65.400	588.90 (516.60)	4.000	159.60 (140.00)
3562	Selective third order catheterisation, arterial or venous, with angiogram/venogram	04.00				73.200	659.20 (578.20)	4.000	159.60 (140.00)
3564	Direct femoral arterial or venous or jugular venous puncture	04.00				37.200	335.00 (293.90)		
3566	Guiding catheter placement, any site arterial or venous, for any intracranial procedure or anteriovenous malformation (AVM)	04.00				85.800	772.60 (677.70)	5.000	199.50 (175.00)
3569	Intravascular pressure studies, arterial or venous, once off per case	04.00				19.800	178.30 (156.40)		
3570	Microcatheter insertion, any cranial vessel and/or pulmonary vessel, arterial or venous (including guiding catheter placement)	04.00				130.800	1177.90 (1033.20)	5.000	199.50 (175.00)
3572	Transcatheter selective blood sampling, arterial or venous	04.00				32.400	291.80 (256.00)		
3574	Spinal angiogram (global fee) including all selective catheterisations	04.00				480.000	4322.40 (3791.60)	5.000	199.50 (175.00)
9.3.2	**Vascular studies: Introduction of contrast medium**								
3563	Direct intravenous for limb	04.00	+			7.400	66.60 (58.40)		
3575	Cut-downs for venography: ADD	04.00	+			11.000	99.10 (86.90)		
9.3.3	**Tomography and cinematography: Computed Tomography**								
6409	CT brain uncontrasted (including posterior fossa)	04.00						5.000	199.50 (175.00)
6410	CT brain with contrast only (including posterior fossa)	04.00						5.000	199.50 (175.00)
6411	CT brain pre AND post contrast (including posterior fossa)	04.00						5.000	199.50 (175.00)
19.11	**Ultrasound investigations**								
	Please note: The calculated amounts in this section are calculated according to the ultrasound unit values								04.00
	Note: See rule GG for requirements for reports and the keeping of records which are also applicable to ultrasonic investigations.								04.00
3596	Intravascular ultrasound per case, arterial or venous, for intervention	04.00		30.000	181.80 (159.50)	30.000	181.80 (159.50)		

3620	Cardiac examination plus Doppler colour mapping	04.00		50.000	303.00 (265.80)	50.000	303.00 (265.80)		
3621	Cardiac examination (MMode)	04.00		25.000	151.50 (132.90)	25.000	151.50 (132.90)		
3622	Cardiac examination: 2 Dimensional	04.00		50.000	303.00 (265.80)	50.000	303.00 (265.80)		
3623	Cardiac examination + effort	04.00	+	10.000	60.60 (53.20)	10.000	60.60 (53.20)		
3624	Cardiac examinations + contrast	04.00	+	10.000	60.60 (53.20)	10.000	60.60 (53.20)		
3625	Cardiac examinations + doppler	04.00		50.000	303.00 (265.80)	50.000	303.00 (265.80)		
3626	Cardiac examination + phonocardiography	04.00	+	10.000	60.60 (53.20)	10.000	60.60 (53.20)		
3627	Ultrasound examination includes whole abdomen and pelvic organs, where pelvic organs are clinically indicated (including liver, gall bladder, spleen, pancreas, abdominal vascular anatomy, para-aortic area, renal tract, pelvic organs)	04.00		60.000	363.50 (318.90)	60.000	363.50 (318.90)		
MODIFIER GOVERNING INTERVENTIONAL RADIOLOGICAL PROCEDURES									
0090	Radiologist's fee for participation in a team: 30,00 radiology units per ½ hour or part thereof for all interventional radiological procedures, excluding any pre- or post-operative angiography, catheterisation, CT-scanning, ultrasound-scanning or x-ray procedures. (Only to be charged if radiologist is hands-on, and not for interpretation of images only)								04.00
9.6	**Magnetic Resonance Imaging (MRI)**								
6100	In order to charge the full fee (600,00 magnetic resonance units) for an examination of a specific single anatomical region, it should be performed with the applicable radio frequency coil including T1 and T2 weighted images on at least two planes								04.00
6101	Where a limited series of a specific anatomical region is performed (except bone tumour), e.g a T2 weighted image of a bone for an occult stress fracture, not more than two-thirds (2/3) of the fee may be charged. Also applicable to all radiotherapy planning studies, per region								04.00
6104	Limited examination of the hypophysis e.g. where a coronal T1 and sagittal T1 series are performed, two-thirds (2/3) of the fee is applicable								04.00
6105	Where, in a limited hypophysis examination, Gadolinium is administered and coronal T1 and sagittal T1 series are repeated, a single full fee for the entire examination is applicable + cost of Gadolinium + disposable items								04.00
6106	Where a magnetic resonance angiography (MRA) of large vessels is performed as primary examination, 100% of the fee is applicable. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability								04.00
6107	Where a magnetic resonance angiography (MRA) of the vessels is performed additional to an examination of a particular region, 50% of the fee is applicable for the angiography. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability								04.00
6108	Where only a gradient echo series is performed with a machine without a recognised angiographic software package with reconstruction ability, 20% of the full fee is applicable specifying that it is a "flow sensitive series"								04.00
6200	Magnetic Resonance Imaging: Per anatomical region: Brain	04.00				400.00 0	2741.20 (2404.60)	5.000	199.50 (175.00)
10	**Clinical Pathology**								
0097	Pathology tests performed by non-pathologists: Where items under Clinical Pathology (section 21) and Anatomical Pathology (section 22) fall within the province of other specialists or general practitioners, the fee is to be charged at two-thirds of the pathologists fee								04.00

	Please note: The calculated amounts in this section are calculated according to the clinical pathology unit values. Note: For fees for Histology and Cytology refer to items 4561-4593 under Section 22: Anatomical Pathology.								04.00
10.1	**Haematology**								
Code	**Description**	**Ver**	**Add**	**Specialists**		**General Practitioners / non-designated Specialists**		**Anaesthesiology**	
				RVU	**Fee**	**RVU**	**Fee**	**RVU**	**Fee**
3755	Full blood count (including items 3739, 3762, 3783, 3785, 3791)	04.00		10.500	77.20 (67.70)	7.000	51.40 (45.10)		
3756	Full cross match	04.00		7.200	52.90 (46.40)	4.800	35.30 (31.00)		

AMBULANCE SERVICES

REGULATIONS DEFINING THE SCOPE OF THE PROFESSION OF EMERGENCY CARE – GENERAL RULES

001	Long distance claims (items 111, 129 and 141) to be rejected unless distance travelled by patient is reflected. Long distance charges may not include item codes 100, 103, 125, 127, 131 or 133. Long distance claims (items 112, 130 and 142) to be rejected unless the distance is reflected. Long distance charges may not include item codes 100, 103, 125, 127, 131 or 133.	04.00
002	No after hours fees may be charged	04.00
003	Item code 151 may only be charged for services provided by a second vehicle (either ambulance or response vehicle) and shall be accompanied by a motivation.	04.00
004	Guidelines for information required on each account: · Name of service · BHF practice number · Address · Telephone number · The name of the patient · Diagnosis of patient's condition · Summary of medical procedures undertaken on patient and vital signs of patient · Summary of all equipment used · The date on which the service was rendered. · Name and HPCSA registration number of care providers · Name, practice number and HPCSA registration number of medical doctor · Response vehicle: Details of vehicle driver and intervention undertaken on patient · The code number of the procedure used in this tariff.	04.00
005	When drugs, consumables and disposable items are used during a procedure, or issued to a patient on discharge, the Fund shall only reimburse the cost of such items, in line with this tariff, if the appropriate code is supplied on the account.	04.00
006	A BLS service (Practice type "51200") may not charge for ILS or ALS, an ILS service (Practice type "51100") may not charge for ALS. An ALS service (Practice type "51000") may charge all codes.	05.04

DEFINITION OF AMBULANCE PATIENT TRANSFER		
	Basic Life Support - A callout where patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered Basic Ambulance Assistant whilst patient in transit. Intermediate Life Support - A callout where the patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered Ambulance Emergency Assistant (AEA). (e.g. Initiating and/or maintaining IV therapy, nebulisation etc.) whilst patient in transit. Advanced Life Support - A callout where patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered Paramedic (CCA and NDIP) whilst patient in transport. This includes all incubated neonatal transfers. NOTES: Incubator transfers require ALS trained personnel in accordance with the HPCSA ruling. · If a hospital or the attending physician requires a Paramedic to accompany the patient on a transfer in the event of the patient needing ALS intervention the doctor requesting the Paramedic must write a detailed motivational letter in order for ALS to be charged. · If a hospital or the attending physician requires a Paramedic to accompany the patient on a transfer in the event of the patient needing ILS intervention the doctor requesting the Paramedic must write a detailed motivational letter in order for ILS to be charged. · In order to bill as an advanced life support call, a registered advanced life support provider must have examined, treated and monitored the patient while in transit to hospital. · In order to bill as an intermediate life support call, a registered intermediate life support provider must have examined, treated and monitored the patient while in transit to hospital. · Where an ALS provider is in attendance at a callout but does not do any interventions at an ALS level on the patient or ALS monitoring and presence is not required, the billing will be based on a lower level dependent on the care given to the patient. (e.g. Paramedic sites IV line or nebulises patient with a B agonist - this falls within the practice of an AEA and thus is to be billed as an ILS call not an ALS call). Where an ILS provider is in attendance at a callout but does not do any interventions at an ILS level on the patient or ILS monitoring and presence is not required, the billing will be BLS. · Where the management undertaken by a paramedic or AEA fall within the scope of practice of a BAA the call must be at a BLS level. Please Note : · The amounts reflected in the NRPL for each level of care is inclusive of any disposables (except for pacing pads, heimlich valves, high capacity giving sets, dial a flow, intra-osseous needles) and drugs used in the management of the patient, as per attached nationally approved medication protocols. · Haemaccel and colloid solution may be charged separately. · Claims for patient discharges home will only be entertained if accompanied by a written motivation from the attending physician who requested such transport - clearly stating why an ambulance is required for such a transport and what medical assistance the patient requires on route.	04.00

DEFINITION OF RESPONSE VEHICLES		
	Response vehicles only - Advance Life Support (ALS) A clear definition must be drawn between the acute primary response and a booked call. 1. The Acute Primary Response is defined as follows: A call that is received for medical assistance to a member of the public who is ill or injured at work, home or in a public area e.g. motor vehicle accident. Should a response vehicle be dispatched to the scene of the emergency and the patient is in need of Advanced Life Support and which is rendered by ALS Personnel e.g. CCA or National Diploma, the respective service shall be entitled to bill on item 131, for such service. However, the service which is transporting the patient shall not be able to levy a bill, as the cost of transportation is included in the ALS rate under items 131 and 133. Furthermore the ALS response vehicle personnel must accompany the patient to hospital to entitle the service to bill for said ALS services rendered. 2. In the event of a service rendering ALS and not having its own ambulance in which to transport the patient to a medical facility, and makes use of another service, only the bill for the response vehicle may be levied as the ALS bill under items 131 and 133. Since the ALS tariff already includes transportation, the response vehicle service is responsible for the bill for the other service provider, which will be levied at a BLS rate. This ensures that there is only one bill levied per patient. Furthermore the response vehicle ALS personnel must accompany the patient to hospital in the ambulance to entitle the service to bill for said ALS services rendered. 3. Should a response vehicle go to a scene and not render any ALS treatment then the said response vehicle may not levy a bill. 4. Notwithstanding that, item 151 applies to all ALS resuscitation per the notes in this schedule. Response vehicle only - Intermediate Life Support (ILS) A clear definition must be drawn between the acute primary response and a booked call. 1. The Acute Primary Response is defined as follows: A call that is received for medical assistance to a member of the public who is ill or injured at work, home or in a public area e.g. motor vehicle accident. Should an ILS response vehicle be dispatched to the scene of the emergency and the patient is in need of Intermediate Life Support and which is rendered by ILS Personnel e.g. AEA, the respective service shall be entitled to bill on item 125, for such service. However, the service which is transporting the patient shall not be able to levy a bill, as the cost of transportation is included in the ILS rate under items 125 and 127. Furthermore the ILS response vehicle personnel must accompany the patient to hospital to entitle the service to bill for said ILS services rendered. 2. In the event of a service rendering ILS and not having its own ambulance in which to transport the patient to a medical facility, and makes use of another service, only the bill for the response vehicle may be levied as the ILS bill under items 125 and 127. Since the ILS tariff already includes transportation, the response vehicle service is responsible for the bill for the other service provider. This ensures that there is only one bill levied per patient. Furthermore the response vehicle ILS personnel must accompany the patient to hospital in the ambulance to entitle the service to bill for said ILS services rendered. 3. Should a response vehicle go to a scene and not render any ILS treatment then the said response vehicle may not levy a bill.	04.00

Code	Description	Ver	Add	Ambulance Services : Advanced Life Support		Ambulance Services : Intermediate Life Support		Ambulance Services : Basic Life Support	
				RVU	Fee	RVU	Fee	RVU	Fee
1	**BASIC LIFE SUPPORT**								
Metropolitan area									
100	Up to 45 minutes	05.04		171.276	692.90	171.276	692.90	171.276	692.90

102	Up to 60 minutes	05.04		228.156	923.10	228.156	923.10	228.156	923.10
103	Every 15 minutes thereafter or part thereof, where specially motivated	05.04		57.084	231.00	57.084	231.00	57.084	231.00
Long distance									
111	Per km (> 100 km) DISTANCE TRAVELLED BY PATIENT	05.04		2.843	11.50	2.843	11.50	2.843	11.50
112	Per km (> 100 km) (BLS return - non patient carrying kilometres) to a maximum of R1986.40	06.02		1.000	4.04	1.000	4.04	1.000	4.04
2	**INTERMEDIATE LIFE SUPPORT**								
Metropolitan area									
125	Up to 45 minutes	05.04		231.226	935.40	231.226	935.40	-	-
127	Every 15 minutes thereafter or part thereof, where specially motivated	05.04		77.075	311.80	77.075	311.80	-	-
Long distance									
129	Per km (> 100 km) DISTANCE TRAVELLED BY PATIENT	05.04		3.850	15.60	3.850	15.60	-	-
130	Per km (> 100 km) (ILS return - non patient carrying kilometres) to a maximum of R1986.40	06.02		1.000	4.04	1.000	4.04	-	-
3	**ADVANCED LIFE SUPPORT / INTENSIVE CARE UNIT**								
Metropolitan area									
131	Up to 60 minutes	05.04		406.641	1645.10	-	-	-	-
133	Every 15 minutes thereafter or part thereof, where specially motivated.	05.04		101.660	411.30	-	-	-	-
Long distance									
141	Per km (> 100 km) DISTANCE TRAVELLED BY PATIENT	05.04		5.072	20.50	-	-	-	-
142	Per km (> 100 km) (ALS return - non patient carrying kilometres) to a maximum of R1986.40	06.02		1.000	4.04	-	-	-	-
4	**ADDITIONAL VEHICLE OR STAFF FOR INTERMEDIATE LIFE SUPPORT, ADVANCED LIFE SUPPORT AND INTENSIVE CARE UNIT**								
151	Resuscitation fee, per incident	04.00		454.000	1836.70	454.000	1836.70	-	-
153	Doctor per hour	04.00		130.000	526.00	130.000	526.00	-	-

	Note : A resuscitation fee may only be billed when a second vehicle (response car or ambulance) with staff (inclusive of a paramedic) attempt to resuscitate the patient using full ALS interventions. These interventions must include one or more of the following: · Administration of advanced cardiac life support drugs. · Cardioversion-synchronised or unsynchronised (defibrillation) · External cardiac pacing · Endotracheal intubation (Oral or nasal) with assisted ventilation	04.00							
	Note : Where a doctor callout fee is charged the name and HPCSA registration number and BHF practise number of the doctor must appear on the bill.								04.00
5.	**AEROMEDICAL TRANSFERS**								
	BY ARRANGEMENT WITH MEDICAL THE FUND								04.00
Rotorwing Rates									
	Definitions: 1. Helicopter rates are determined according to aircraft type 2. Day light operations are defined from Sunrise to Sunset (and night operations from Sunset to Sunrise) 3. If flying time is mostly in night time (as per definition above), then bill night time operation rates (type C) 4. Call out charge includes Basic Call Cost plus other flying time incurred, Staff and consumables cost can only be charged if a patient has been treated. 5. Flying time is billed for minimum of 30 minutes and thereafter in 15 minute increments. 6. A 2nd Patient is transferred at 50% reduction of Basic Call and Flight cost, but Staff and Consumables costs remain per patient. (Only if aircraft capability allows for multiple patients) 7. Rates are calculated according to time; from throttle open, to throttle closed. 8. Group A - C must fall within the Cat 138 Ops as determined by Civil Aviation. 9. Hot loads restricted to 8 minutes ground time and must be denoted.								04.00
	AIRCRAFT TYPE A (RA): HB206L, HB204 / 205, HB407, AS360, EC120, MD600, AS350, A119 AIRCRAFT TYPE B (RB) & Ca (DAY OPERATIONS) (RC) BO105, 206CT, AS355, A109 AIRCRAFT TYPE Cb (NIGHT OPERATIONS) (RC) HB222, HB212 / 412, AS365, S76, HB427, MD900, BK117, EC135, BO105 AIRCRAFT TYPE D (RESCUE) H500, HB206B, AS350, AS315, FH1100								04.00
500	Basic Call Cost (Start up)	04.00							
Flying Time									
531	30 minutes	04.00							

533	45 minutes	04.00							
535	60 minutes	04.00							
537	75 minutes	04.00							
539	90 minutes	04.00							
541	105 minutes	04.00							
543	120 minutes	04.00							
Staff and Consumables									
581	30 minutes	04.00							
583	45 - 75 minutes	04.00							
585	90 - 105 minutes	04.00							
587	120 minutes	04.00							
Aircraft Type D									
591	Hourly rate plus 20%	04.00							
Winching									
595	Winching, per lift	04.00							
Fixed Wing Rates									
	DEFINITIONS: 1. Group A must fall within the Cat 138 Ops as determined by Civil Aviation. 2. No fee structure has been provided for Group B, as emergency charters could include any form of aircraft. It would be impossible to specify costs over such a broad range. These can only be used during emergencies when no Group A aircraft are available. 3. Staff and consumables cost can only be used if the patient has been treated. 4. 2nd patient transferred at 50% reduction of Basic Call and Flight Cost, but Staff and consumables costs remain per patient. (only if aircraft capability allows for multiple patients)								04.00
Group A (FA)									
	Composed of flying cost per kilometer, staff cost per hour and equipment cost								04.00
Staff cost per hour									
621	Doctor	04.00							
623	ICU Sister	04.00							
625	Paramedic	04.00							
Equipment Cost									
631	Per patient, per hour	04.00							
Aircraft cost (per kilometer)									
651	Beechcraft Duke	04.00							
653	Lear 24F	04.00							
655	Lear 35	04.00							
657	Falcon 10	04.00							
659	King Air 200	04.00							

661	Mitsubishi MU2	04.00								
663	Cessna 402	04.00								
665	Beechcraft Baron	04.00								
667	Citation II	04.00								
669	Pilatus PC12	04.00								
Group B - Emergency Charters										
	1. No staff and equipment fee allowed. 2. Cost to be reviewed per case. 3. Only allowed if a Group A aircraft is not available within an optimal period for transportation and stabilisation of the patient.									04.00
6	**NATIONALLY APPROVED MEDICATIONS WHICH MAY BE ADMINISTERED BY HPCSA-REGISTERED AMBULANCE PERSONNEL ACCORDING TO HPCSA-APPROVED PROTOCOLS**									
	Registered Basic Ambulance Assistant Qualification · Oxygen · Entonox · Oral Glucose Registered Ambulance Emergency Assistant Qualification As above, plus · Intravenous fluid therapy · Intravenous dextrose 50% · B2 stimulant nebuliser inhalant solutions (Hexoprenaline, Fenoterol, Sulbutamol) · Soluble Aspirin Registered Paramedic Qualification As above, plus · Oral glyceryl trinitrate, activated charcoal · Ipratropium bromide inhalant solution · Endotracheal Adrenaline and Atropine · Intravenous Adrenaline, Atropine, Calcium, Hydrocortisone, Lignocaine, Naloxone, Sodium bicarbonate, Hetaclopramide · Intravenous Diazepam, Flumazenil, Furosemide, Hexoprenaline, Midazolam, Nalbuphine and Tramadol may only be administered after permission has been obtained from the relevant supervising medical officer. · Pacing and synchronised cardioversion require the permission of the relevant supervising medical officer.									04.00

SERVICES BY HOSPITALS		
GENERAL RULES		
SCHEDULE		
B	The charges relating to each type of hospital/unattached operating theatre unit are indicated in the relevant column opposite the item codes.	04.00
C	The charges indicated in Section 5 hereof, are applicable to both categories of such hospitals and unattached operating theatre units.	04.00
D	When drugs, consumables and disposable items are used during a procedure, or issued to a patient on discharge, the Fund shall only reimburse the cost of such items, in line with this tariff, if the appropriate code is supplied on the account.	04.00
E.1	Procedure for the classification of hospitals:	04.00
E.1.1	Inspections of private hospitals or unattached operating theatre units/day clinics having practice code numbers commencing with the digits 057, 058 or 077 will be conducted by an independent agency on behalf of the BHF. Applications to be addressed in writing to the BHF.	04.00
E.3.2	The provisions referred to in E.1.1 shall apply mutatis mutandis to all approved specialised intensive care units, specialised theatres, catheterisation laboratories and trauma units.	04.00
F.1	Procedures to consider applications by institutions to be classified as unattached operating theatre units having a practice code number commencing with the digits 77 and for the reclassification of unattached operating theatre units with 76 practice numbers.	04.00
F.1.1	Inspections of new unattached theatre operating units and units having practice code numbers commencing with the digit 76, to be reclassified as approved unattached operating theatre units having practice numbers commencing with the digits 77 will be conducted by an independent agency on behalf of the BHF. Applications to be addressed in writing to the BHF.	04.00
G	All accounts submitted by private and unattached operating theatre units/day clinics shall comply with all of the requirements in terms of the Medical Schemes Act, Act No. 131 of 1999. Where possible, such accounts shall also reflect the practice code numbers and names of the surgeon, the anaesthetist and of any assistant surgeon who may have been present during the course of an operation.	04.00
H	All accounts shall be accompanied by a copy of the relevant theatre accounts specifying all details of items charged, as well as all the procedures performed. Photocopies of all other documents pertaining to the patients account must be provided on request. The Fund shall have the right to inspect the original source documents at the hospital/unattached operating theatre unit concerned.	04.00
I	All accounts containing items which are subject to a discount shall indicate such items individually and shall show separately the gross amount of the discount.	04.00

1	**ACCOMMODATION**								
Ward fees									
	Hospitals and unattached operating theatre units shall indicate the exact time of admission and discharge on all accounts. In the case of hospitals, the day admission fee (code 007) shall be charged in respect of all patients admitted as day patients and discharged before 23h00 on the same date. The following will be applicable to items 001 to 005, 015, 020, 200, 201, 202 and 215 to 218: On the day of admission: If accommodation is less than 12 hours from time of admission : half the daily rate If accommodation is more than 12 hours from time of admission: full daily rate Two half day fees would be applicable when a patient is transferred internally between any ward and any specialised unit. On day of discharge: If accommodation is less than 12 hours: half the daily rate If accommodation is more than 12 hours: full daily rate The items listed as non-recoverable in Annuxure B shall be deemed to be included in ward fees, and no charge in respect thereof may be levied.								04.00
1.1	**General Wards**								
Code	**Description**	**Ver**	**Add**	**Private Hospitals ('A' - Status)**		**Private Hospitals ('B' - Status)**		**Approved U O T U / Day clinics**	
				RVU	**Fee**	**RVU**	**Fee**	**RVU**	**Fee**
001	Surgical cases: per day.	04.00		36.063	907.90 (796.40)	36.063	907.90 (796.40)	-	-
002	Thoracic and neurosurgical cases (including laminectomies and spinal fusion): per day	04.00		37.888	953.90 (836.80)	37.888	953.90 (836.80)	-	-
005	Paediatric cases (under 14 years of age)	04.00		44.513	1120.70 (983.10)	44.513	1120.70 (983.10)	-	-
	Day admissions - all patients admitted as day patients and discharged before 23h00 on the same day	04.00							
007	Day admission (irrespective of type of ward patient is admitted to, i.e. general, neurosurgical or paediatric) which includes all patients discharged by 23h00 on date of admission	04.00		23.079	581.00 (509.60)	23.079	581.00 (509.60)	19.725	496.60 (435.60)
014	Overnight fee - Medical practitioner to pre-authorise all overnight admissions	04.00		-	-	-	-	8.692	218.80 (191.90)
Natural births									
009	First day (Day of confinement).	04.00		174.458	4392.20 (3852.80)	174.458	4392.20 (3852.80)	-	-
010	Subsequent day(s).Per day	04.00		60.096	1513.00 (1327.20)	60.096	1513.00 (1327.20)	-	-

Caesarean									
012	First day (Day of confinement).	04.00		270.992	6822.50 (5984.60)	270.992	6822.50 (5984.60)	-	-
013	Subsequent day(s). Per day	04.00		59.583	1500.10 (1315.90)	59.583	1500.10 (1315.90)	-	-
	Note: The following fees (items 015 and 016) are included in the above per diem fees, and may only be charged on a fee for service account	04.00							
015	Nursery fee.	04.00		16.925	426.10 (373.80)	16.925	426.10 (373.80)	-	-
016	Delivery room. This item is not applicable for deliveries by registered midwifes in private practice.	05.03		72.746	1831.50 (1606.60)	72.746	1831.50 (1606.60)	-	-
018	Subsequent day(s) excluding nursery fee	04.00		42.963	1081.60 (948.80)	42.963	1081.60 (948.80)	-	-
Epidural fee									
011	Use of epidural anaesthesia for MATERNITY CASES ONLY. (Note: This item includes all surgicals and nursing but no ethicals)	04.00		26.500	667.20 (585.30)	26.500	667.20 (585.30)	-	-
1.2	**Private Wards**								
020	Private ward Hospitals shall obtain a certificate motivating for the necessity for accommodation in a private ward, from the attendant practitioner, and such certificate shall be forwarded to the Fund for pre-authorisation. General ward fees are applicable to isolation.	04.00		46.608	1173.40 (1029.30)	46.608	1173.40 (1029.30)	-	-
021	Private ward on member's request or for convenience of hospital will be funded at scale of benefits for general ward.	04.00		-	-	-	-	-	-
1.3	**Special Care Units**								
	Specialised units are defined as: Intensive Care Unit (ICU), Cardio-Thoracic Intensive Care Unit (CTICU), Neonatal Intensive Care Unit (NICU), High Care (HC), Neonatal High Care (NHC), A & B.								04.00
	Hospitals shall obtain a certificate stating the reason for accommodation in any specialised or other intensive care unit or in high care ward including neonatal intensive care and high care from the attending practitioner, and such certificate showing the date and time of admission and discharge from the unit shall be forwarded to the Fund. No charge may be levied to the Fund for special or private nursing.								04.00
200	Specialised ICU per day	04.00		195.088	4911.50 (4308.30)	195.088	4911.50 (4308.30)	-	-
	(Subject to a maximum of 1 day. Pre-authorisation required for every additional day thereafter. Item 201 will apply if no pre-authorisation is obtained. Use of this unit shall be limited to cardio-thoracic surgery, major vascular surgery and neuro-surgery cases involving surgery on the brain and spinal cord).	04.00							

201	Intensive Care Unit: Per day.	04.00		148.479	3738.10 (3279.00)	148.479	3738.10 (3279.00)	-	-
202	Neonatal Intensive Care Unit: Per day.	04.00		184.863	4654.10 (4082.50)	184.863	4654.10 (4082.50)	-	-
	(The charges referred to under items 200, 201 and 202 include the use of all equipment except: Bennett MA, Servo and Bear ventilators or equivalent apparatus plus the cost of oxygen)	04.00							
215	High Care Ward, Per day.	04.00		95.108	2394.40 (2100.40)	95.108	2394.40 (2100.40)	-	-
216	Neonatal High Care Ward `A' (Intensive nursing and monitoring)	04.00		103.308	2600.90 (2281.50)	103.308	2600.90 (2281.50)	-	-
217	Neonatal High Care Ward `B' (Standard nursing and monitoring)	04.00		67.538	1700.30 (1491.50)	67.538	1700.30 (1491.50)	-	-
	Note: Once the baby has been stabilised and no longer requires ICU care but is not ready to be returned to the general nursery, no additional equipment charges, eg phototherapy may be charged. All admissions to units/wards referred to under 201 to 202 shall be confirmed with the Fund for each 72 hours and 215 to 218 shall be confirmed weekly.	04.00							
2	**EMERGENCY UNIT**								
2.1	**Emergency Unit Fee**								
105	Resuscitation fee charged only if patient has been resuscitated and intubated in a trauma unit.	04.00		45.858	1154.50 (1012.70)	45.858	1154.50 (1012.70)	-	-
302	For all consultations which require the use of a procedure room or nursing input, e.g. for application of plaster of Paris, stitching of wounds, insertion of IV Therapy. Includes the use of the procedure room. No per minute charge may be levied.	04.00		10.533	265.20 (232.60)	10.533	265.20 (232.60)	10.533	265.20 (232.60)
	Note: The procedure room fee (071) cannot be charged in addition to 302	04.00							
2.2	**THEATRE FEES**								
061	Excimer Laser Theatre fee, per minute	04.00		0.650	16.40 (14.40)	0.650	16.40 (14.40)	0.650	16.40 (14.40)
	Items listed as non-recoverable per Annuxure B of the National Health Reference Price List (in respect of Private Hospitals) shall be deemed to be included in theatre fees, and no charge in respect thereof may be levied.	04.00							
2.3	**Major theatre**								
	In addition to the theatre charge calculated as above, a surcharge (modifier 0002 and/or 0003) shall be allowed in cases where specialised theatres referred to in General Rule E.1.1 are utilised for the performance of any of the undermentioned procedures, whether carried out individually or in combination with each other, this surcharge shall be deemed to cover the equipment in the criteria. Note: Specialised intensive care units and specialised theatres are to be individually inspected and approved by the BHF								04.00
0002	Modifier 0002: Orthopaedic, Neurosurgical and Vascular: · Femoro- popliteal bypasses · Neurosurgery (Surgery on the brain and spinal cord only, excludes neurolysis)	04.00		48.309	1216.23 (1066.87)	48.309	1216.23 (1066.87)	-	-

0003	Modifier 0003: Cardiac surgery Cardio-thoracic and Cardio-vascular surgery · All open heart surgery, with or without the insertion of a prosthesis, coronary artery bypass grafts and heart transplants. Includes all equipment (except item 513), no additional fees may be charged NOTE: The above surcharge will also be applicable to approved provincial hospitals	04.00		110.688	2786.68 (2444.46)	110.688	2786.68 (2444.46)	-	-
Time in Theatre									
081	Charge per minute (which includes 0.16c per minute for those items in the surgical basket).	04.00		1.554	39.10 (34.30)	1.554	39.10 (34.30)	1.329	33.50 (29.40)
	The exact time of admission to and discharge from theatre shall be stated, upon which the theatre charge shall be calculated as follows	04.00							
Specialised Theatre Modifiers									
3	**PROCEDURAL FEES**								
	The fees quoted for items 052, 053 and 055 shall be all-inclusive and no additional charges of whatsoever nature may be raised, except for items 515, 529, 533, 535 and any items chargeable in terms of Section 4 and 5 hereof. NOTE: Ward fees may however be chargeable together with items 053 and 055.								05.03
3.1	**Procedures**								
052	Procedures carried out in X-ray department using hospital owned equipment under general anaesthetic.	04.00		14.342	361.10 (316.80)	14.342	361.10 (316.80)	14.342	361.10 (316.80)
053	Angiograms.	04.00		14.342	361.10 (316.80)	14.342	361.10 (316.80)	-	-
3.2	**Catheterisation laboratory procedures**								
	Note: A certificate indicating the level of the catheterisation laboratory used, should be signed by the relevant doctor, indicating the information if required by the Fund.								05.03
	The fees quoted for items 054, 056, 070 and 073 shall be all-inclusive and no additional charges of whatsoever nature may be raised, except for items 515, 529, 533 and 535 and any items chargeable in terms of Section 4 and 5 hereof. NOTE: ward fees may however be chargeable together with items 054, 055, 056, 070 and 073.								05.03
054	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy when carried out in a facility equipped with a recognised analogue monoplane unit, and in a hospital equipped to perform the relevant surgery, as approved by the committee established in terms of General Rule E.1.1 NB: For EPS studies, the Bard Apparatus (item 529) must be charged additionally.	04.00		51.446	1295.20 (1136.10)	51.446	1295.20 (1136.10)	-	-
056	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy when carried out in a facility equipped with a recognised analogue bi-plane unit, and in a hospital equipped to perform the relevant surgery, as approved by the committee established in terms of General Rule E.1.1	04.00		96.929	2440.30 (2140.60)	96.929	2440.30 (2140.60)	-	-

070	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy when carried out in a facility equipped with a recognised digital bi-plane unit, and in a hospital equipped to perform the relevant surgery, as approved by the committee established in terms of General Rule E.1.1. NB: EPS for cardiac ablations - items 529 must be charged additionally.	04.00		251.804	6339.40 (5560.90)	251.804	6339.40 (5560.90)	-	-
073	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy when carried out in a facility equipped with a recognised digital monoplane unit, and in a hospital equipped to perform the relevant surgery, as approved by the committee established in terms of General Rule E.1.1	04.00		186.233	4688.60 (4112.80)	186.233	4688.60 (4112.80)	-	-
075	Catheterisation laboratory film price (once per procedure)	04.00		5.546	139.60 (122.50)	5.546	139.60 (122.50)	-	-
3.3	**Stereotactic radiosurgery**								
	Included in item 430 Stereotactic frames and attachments Linear Accelerator Specialised graphic planning, hardware and software Simulator and dark rooms Stereotactic masks All disposables 4 to 20 Graphic transparencies (including 1 week of planning) 2 trained radiographers Fixation and immobilisation Nuclear Specialist Medical Physicist Duration 1 - 4 hours 2 treatment radiographers Excluded from fee Other medical practitioners CT & MRI								04.00
	Item 399 is an all- inclusive single global radiosurgery fee, payable to a hospital. This item includes item 430, all imaging and all clinical fees. The hospital is responsible for reimbursement of all fees to all the professional providers of service involved in the treatment rendered under this item.	04.00							
430	Global fee for stereotactic radiosurgery	04.00		2520.600	63458.60 (55665.40)	2520.600	63458.60 (55665.40)	-	-
4	**STANDARD CHARGES FOR EQUIPMENT**								
4.1	**Gases**								
	Price increases: Should a change occur in the manufacturer's price of any item listed hereunder, the new price shall be as notified								04.00
Oxygen and Nitrous Oxide									
	For both gases together, per minute								04.00
283	PWV area	04.00		0.110	2.77 (2.43)	0.110	2.77 (2.43)	0.110	2.77 (2.43)

701	Cape Town	04.00		0.151	3.80 (3.33)	0.151	3.80 (3.33)	0.151	3.80 (3.33)
702	Port Elizabeth	04.00		0.134	3.37 (2.96)	0.134	3.37 (2.96)	0.134	3.37 (2.96)
703	East London	04.00		0.149	3.75 (3.29)	0.149	3.75 (3.29)	0.149	3.75 (3.29)
704	Durban	04.00		0.138	3.47 (3.04)	0.138	3.47 (3.04)	0.138	3.47 (3.04)
705	Other areas	04.00		0.123	3.10 (2.72)	0.123	3.10 (2.72)	0.123	3.10 (2.72)
Oxygen, ward use									
	Fee for oxygen, per quarter hour or part thereof, outside the operating theatre complex								04.00
284	PWV area	04.00		0.162	4.08 (3.58)	0.162	4.08 (3.58)	0.162	4.08 (3.58)
710	Cape Town	04.00		0.268	6.75 (5.92)	0.268	6.75 (5.92)	0.268	6.75 (5.92)
711	Port Elizabeth	04.00		0.258	6.50 (5.70)	0.258	6.50 (5.70)	0.258	6.50 (5.70)
712	East London	04.00		0.248	6.24 (5.47)	0.248	6.24 (5.47)	0.248	6.24 (5.47)
713	Durban	04.00		0.210	5.29 (4.64)	0.210	5.29 (4.64)	0.210	5.29 (4.64)
714	Other areas	04.00		0.200	5.04 (4.42)	0.200	5.04 (4.42)	0.200	5.04 (4.42)
Oxygen, recovery room or emergency room									
	Flat rate for oxygen per case								04.00
720	PWV area	04.00		0.322	8.11 (7.11)	0.322	8.11 (7.11)	0.322	8.11 (7.11)
721	Cape Town	04.00		0.533	13.40 (11.80)	0.533	13.40 (11.80)	0.533	13.40 (11.80)
722	Port Elizabeth	04.00		0.513	12.90 (11.30)	0.513	12.90 (11.30)	0.513	12.90 (11.30)
723	East London	04.00		0.492	12.40 (10.90)	0.492	12.40 (10.90)	0.492	12.40 (10.90)
724	Durban	04.00		0.421	10.60 (9.30)	0.421	10.60 (9.30)	0.421	10.60 (9.30)
725	Other areas	04.00		0.398	10.00 (8.77)	0.398	10.00 (8.77)	0.398	10.00 (8.77)
Oxygen in Theatre									
	Fee for oxygen per minute in the operating theatre when no other gas administered								04.00
730	PWV area	04.00		0.010	0.25 (0.22)	0.010	0.25 (0.22)	0.010	0.25 (0.22)
731	Cape Town	04.00		0.018	0.45 (0.39)	0.018	0.45 (0.39)	0.018	0.45 (0.39)
732	Port Elizabeth	04.00		0.017	0.43 (0.38)	0.017	0.43 (0.38)	0.017	0.43 (0.38)
733	East London	04.00		0.017	0.43 (0.38)	0.017	0.43 (0.38)	0.017	0.43 (0.38)
734	Durban	04.00		0.013	0.33 (0.29)	0.013	0.33 (0.29)	0.013	0.33 (0.29)
735	Other areas	04.00		0.013	0.33 (0.29)	0.013	0.33 (0.29)	0.013	0.33 (0.29)
Carbon Dioxide									
291	Per minute	04.00		0.020	0.50 (0.44)	0.020	0.50 (0.44)	0.020	0.50 (0.44)
Laser Mix									
292	Per minute	04.00		0.387	9.74 (8.54)	0.387	9.74 (8.54)	0.387	9.74 (8.54)

Entonox									
293	Per 30 minutes	04.00		3.675	92.50 (81.10)	3.675	92.50 (81.10)	3.675	92.50 (81.10)
5	**Inhalation anaesthetics**								
	Price increases: Should a change occur in the manufacturer's price of any item listed hereunder, the new price shall be as notified								04.00
285	Halothane (Halothane): per minute	04.00		0.041	1.03 (0.90)	0.041	1.03 (0.90)	0.041	1.03 (0.90)
752	Ethrane (Enflurane): per minute	04.00		0.218	5.49 (4.82)	0.218	5.49 (4.82)	0.218	5.49 (4.82)
753	Forane (Isoflurane): per minute	04.00		0.205	5.16 (4.53)	0.205	5.16 (4.53)	0.205	5.16 (4.53)
754	Isofor (Isoflurane): per minute	04.00		0.186	4.68 (4.11)	0.186	4.68 (4.11)	0.186	4.68 (4.11)
755	Ultane (Sevoflurane): per minute	04.00		0.376	9.47 (8.31)	0.376	9.47 (8.31)	0.376	9.47 (8.31)
756	Suprane (Desflurane), per minute	04.00		0.320	8.06 (7.07)	0.320	8.06 (7.07)	0.320	8.06 (7.07)
757	Aerrane (Isoflurane): per minute	04.00		0.167	4.20 (3.68)	0.167	4.20 (3.68)	0.167	4.20 (3.68)
758	Alyrane (Enflurane): per minute	04.00		0.168	4.23 (3.71)	0.168	4.23 (3.71)	0.168	4.23 (3.71)
759	Fluothane (Halothane), per minute	04.00		0.040	1.01 (0.89)	0.040	1.01 (0.89)	0.040	1.01 (0.89)

SERVICES BY RADIOLOGISTS

This schedule is for the exclusive use of registered specialist radiology practices (Pr No "038") and nuclear medicine practices (Pr No "025"). "025" practices may only charge the codes with a 3rd digit of 9. "038" practices may charge all codes except codes with a 3rd digit of 9. Practitioners registered as both radiologists and nuclear physicians may charge all codes.

This schedule must be used in conjunction with the Radiological Society of S A Guidelines.

Code Structure Framework

a. The tariff code consists of 5 digits

i. 1st digit indicates the main anatomical region or procedural category.

- 0 = General (non specific)
- 1 = Head
- 2 = Neck
- 3 = Thorax
- 4 = Abdomen and Pelvis (soft tissue)
- 5 = Spine, Pelvis and Hips
- 6 = Upper limbs
- 7 = Lower limbs
- 8 = Interventional
- 9 = Soft tissue regions (nuclear medicine)

eg "Head" = 1xxxx

ii. 2nd digit indicates the sub region within a main region or category

eg. "Head / Skull and Brain" = 10xxx

iii. 3rd digit indicates modality

- 1 = General (Black and White) x-rays
- 2 = Ultrasound
- 3 = Computed Tomography
- 4 = Magnetic Resonance Imaging
- 5 = Angiography
- 6 = Interventional radiology
- 9 = Nuclear Medicine (Isotopes)

eg: "Head / Skull and Brain / General x-ray" = 101xx

iv. 4th and 5th digits are specific to a procedure / examination

eg. "Head / Skull and Brain / General / X-ray of the skull" = 10100.

Guidelines for use of coding structure

- The vast majority of the codes describe complete procedures / examination and their use for the appropriate studies is self-explanatory.
- Some codes may have multiple applications and their use is described in notes associated with each code
- Codes 00510 to 00560 (Angiography machine codes) may only be used by owners of the equipment and who have registered such equipment with the Board of Healthcare Funders / RSSA.
- The machine codes 00510, 00520, 00530, 00540, 00550, 00560 may not be added to 60540, 60550, 70530, 70535 (Antegrade Venography, upper and lower limbs)
- Where public sector hospital equipment is used for a procedure, the units will be reduced by 33.33%.

Consumables

- Contrast Medium
  - o Prior to the implementation of Act 90, contrast will be billed according to the official 2004 RSSA reimbursement price list, without mark up.
  - o After the implementation of Act 90, contrast medium will be billed according to the suppliers' list price, without mark up.
- Angiography catheters, angioplasty balloons, stents, coils and other embolisation materials, guide wires and drains are to be billed at net acquisition cost, without mark up, until the implementation of Act 90.
- All other consumables are to be billed at net acquisition price, until the implementation of Act 90. Thereafter Act 90 regulations apply.
- The cost of film is included in the comprehensive procedure codes and is not billed for separately.
- Appropriate codes must be provided for consumables.

General Comments on Procedural Codes

- All x-ray tomography codes are stand alone studies and may be used as a unique study or in combination with the appropriate regional study if done simultaneously. May not be added to 20130, 42110, 42115.
- Setting of sterile tray is included in all appropriate procedure codes.
- Where introduction of contrast is necessary eg. angiography, etc, the codes used for the procedures are comprehensive and include the introduction of contrast or isotopes.
- The use of Doppler or Colour Doppler as an adjunct to a study (eg small parts thyroid) is included in the code for that study.
- CT Angiography (10330, 20330, 32300, 32310, 44300, 44310, 44320, 44330, 60310, 70310, 70320) are stand alone studies and may not be added to the regional contrasted studies (see 10335, 20340, 20350, 44325 for combined studies).
- Angiography and interventional procedures include selective and super selective catheterization of vessels as are necessary to perform the procedures.

Codes 00230 (Ultrasound guidance), 00320 (CT guidance) and 00430 (MR guidance) are stand alone procedures that include the regional study and may not be added to any of the ultrasound, CT or MR regional studies

General Codes

Modifiers

00091	Radiology and nuclear medicine services rendered to hospital inpatients	04.00
00093	A reduction of one third (33.33%) will apply to radiological examinations where hospital equipment it used	04.00

Equipment / Diagnostic

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
00090	Consumables used in radiology procedures: cost price PLUS 26% (up to a maximum of R26,00). (Where applicable, VAT should be added to the above).	05.04				-	-
	Appropriate code to be provided. See separate codes for contrast and isotopes	04.00					
00130	X-ray with mobile unit in other facility	04.00				1.900	115.30 (101.10)
	To be added to applicable procedure codes eg 30100.	04.00					
00135	X-ray control view in theatre any region	04.00				5.260	319.10 (279.90)

Call and assistance								
	• Emergency call out code 01010 only to be used if radiologist is called out to the rooms to report on an examination after normal working hours. May not be used for routine reporting during extended working hours. • Emergency call out code 01020 only to be used when a radiologist reports on subsequent cases after having been called out to the rooms to report an initial after hours procedure. This code may also be used for home tele-radiology reporting of an emergency procedure. May not be used for routine reporting during normal or extended working hours. • Radiologist assistance in theatre code 01030 only to be used if the radiologist is actively involved in assisting another radiologist or clinician with a procedure. • Radiographer assistance in theatre 01040 may not be used for procedures performed in facilities owned by the radiologist; ie only for attendance in hospital theatres etc. Does not apply to Bed Side Unit (BSU) examinations. • Second opinion consultations only to be used if a written report is provided as indicated in codes 01050, 01055, 01060. Not intended for ad hoc verbal consultations.							05.05
01010	Emergency call out fee, first case	04.00					3.000	182.00 (159.60)
01020	Emergency call out fee, subsequent cases same trip	04.00					2.000	121.30 (106.40)
01030	Radiologist assistance in theatre, per half hour	04.00					6.000	364.00 (319.30)
01040	Radiographer attendance in theatre, per half hour	04.00					1.600	97.10 (85.20)
01200	Ultrasound procedure after hours, per procedure	04.00					4.000	-
Monitoring								
	• ECG / Pulse oximetry monitoring (02010). Use for monitoring patients requiring conscious sedation during imaging procedure. Not to be used as a routine.							04.00
02010	ECG/pulse oximeter monitoring	04.00				2.000		121.30 (106.40)
Head								
Skull and Brain								
	Codes 10100 (skull) and 10110 (tomography) may be combined.							04.00
10100	X-ray of the skull	04.00				3.860		234.20 (205.40)
10110	X-ray tomography of the skull	04.00				4.300		260.80 (228.80)
10200	Ultrasound of the brain – Neonatal	04.00				7.380		447.70 (392.70)
10210	Ultrasound of the brain including doppler	04.00				13.220		802.00 (703.50)
10220	Ultrasound of the intracranial vasculature, including B mode, pulse and colour doppler	04.00				15.040		912.40 (800.40)
10300	CT Brain uncontrasted	04.00				22.650		1374.00 (1205.30)
10310	CT Brain with contrast only	04.00				33.280		2018.80 (1770.90)
10320	CT Brain pre and post contrast	04.00				40.480		2455.60 (2154.00)
10325	CT brain pre and post contrast for perfusion studies	05.03				49.100		2978.50 (2612.70)

Cervical							
	Code 51100 (stress) is a stand alone study and may not be added to 51110, 51120 (cervical spine), 51160 (myelography) and 51170 (discography). Code 51140 (tomography) may be combined with 51110 or 51120 (spine). Code 51160s (myelography) and 51170 (discography) include fluoroscopy and introduction of contrast (00140 may not be added). Code 51300 (CT) limited - limited to a single cervical vertebral body. Code 51310 (CT) regional study - 2 vertebral bodies and intervertebral disc spaces. Code 51320 (CT) complete study - an extensive study of the cervical spine. Code 51340 (CT myelography) – post myelographic study and includes all disc levels, includes fluoroscopy and introduction of contrast (00140 may not be added).					04.00	
51100	X-ray of the cervical spine, stress views only	04.00				4.140	251.10 (220.30)
51110	X-ray of the cervical spine, one or two views	04.00				3.010	182.60 (160.20)
51120	X-ray of the cervical spine, more than two views	04.00				4.280	259.60 (227.70)
51130	X-ray of the cervical spine, more than two views including stress views	04.00				7.580	459.80 (403.30)
51310	CT of the cervical spine – regional study	04.00				13.910	843.80 (740.20)
51320	CT of the cervical spine – complete study	04.00				37.130	2252.40 (1975.80)
51330	CT of the cervical spine pre and post contrast	04.00				58.850	3570.00 (3131.60)
51340	CT myelography of the cervical spine	04.00				47.190	2862.60 (2511.10)
51350	CT myelography of the cervical spine following myelogram	04.00				21.690	1315.80 (1154.20)
51400	MR of the cervical spine, limited study	04.00				44.400	2693.40 (2362.60)
51410	MR of the cervical spine and cranio-cervical junction	04.00				64.820	3932.10 (3449.20)
51420	MR of the cervical spine and cranio-cervical junction pre and post contrast	04.00				102.140	6196.00 (5435.10)
Thoracic							
	Code 52120 (tomography) may be combined with 52100 or 52110 (spine). Code 52150 (myelography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 52300 (CT) limited study – limited to a single thoracic vertebral body. Code 52305 (CT) regional study - 2 vertebral bodies and intervertebral disc paces. Code 52310 (CT) complete study - an extensive study of the thoracic spine. Code 52330 (CT myelography) - post myelographic study and includes all disc levels, flubroscopy and introduction of contrast (00140 may not be added).					04.00	
52100	X-ray of the thoracic spine, one or two views	04.00				3.210	194.70 (170.80)
52110	X-ray of the thoracic spine, more than two views	04.00				4.000	242.60 (212.80)

52120	X-ray tomography thoracic spine	04.00				4.300	260.80 (228.80)
52140	X-ray of the thoracic spine, more that two views including stress views	04.00				6.640	402.80 (353.30)
52305	CT of the thoracic spine – regional study	04.00				13.910	843.80 (740.20)
52310	CT of the thoracic spine complete study	04.00				35.780	2170.50 (1903.90)
52320	CT of the thoracic spine pre and post contrast	04.00				58.850	3570.00 (3131.60)
52330	CT myelography of the thoracic spine	04.00				48.090	2917.20 (2558.90)
52340	CT myelography of the thoracic spine following myelogram	04.00				20.370	1235.70 (1083.90)
52400	MR of the thoracic spine, limited study	04.00				46.600	2826.80 (2479.60)
52410	MR of the thoracic spine	04.00				64.340	3903.00 (3423.70)
52420	MR of the thoracic spine pre and post contrast	04.00				101.420	6152.30 (5396.80)
Lumbar							
	Code 53100 (stress) is a stand alone study and may not be added to 53110, 53120 (lumbar spine), 53160 (myelography) and 53170 (discography). Code 53140 (tomography) may be combined with 53110 or 53120 (spine). Codes 53160 (myelography) and 53170 (discography) include fluoroscopy and introduction of contrast (00140 may not be added). Code 53300 (CT) limited study – limited to a single lumbar vertebral body. Code 53310 (CT) regional study - 2 vertebral bodies and intervertebral disc spaces. Code 53320 (CT) complete study - an extensive study of the lumbar spine. Code 53340 (CT myelography) - post myelographic study and includes all disc levels, fluoroscopy and introduction of contrast (00140 may not be added).						04.00
53110	X-ray of the lumbar spine, one or two views	04.00				3.560	216.00 (189.50)
53120	X-ray of the lumbar spine, more than two views	04.00				4.460	270.60 (237.40)
53130	X-ray of the lumbar spine, more that two views including stress views	04.00				7.520	456.20 (400.20)
53300	CT of the lumbar spine limited study	04.00				9.500	576.30 (505.50)
53310	CT of the lumbar spine – regional study	04.00				13.910	843.80 (740.20)
53320	Ct of the lumbar spine complete study	04.00				37.640	2283.30 (2002.90)
53330	CT of the lumbar spine pre and post contrast	04.00				58.850	3570.00 (3131.60)
53410	MR of the lumbar spine	04.00				64.320	3901.80 (3422.60)

53420	MR of the lumbar spine pre and post contrast	04.00				103.290	6265.80 (5496.30)
Knee							
	Codes 72140 and 72145 (patella) may not be added to 72100, 72105, 72110, 72115, 72130, 72135 (knee views) Code 72160 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 72170 (introduction of contrast) may be combined with 72300 and 72305 (CT) or 72400 and 72405 (MR). The combination of 72160 (arthrography) and 72300 and 72305 (CT) or 72400 and 72405 (MR) is not supported except in exceptional circumstances with motivation.					04.00	
72100	X-ray of the left knee one or two views	04.00				2.770	168.00 (147.40)
72105	X-ray of the right knee one or two views	04.00				2.770	168.00 (147.40)
72120	X-ray of the left knee including patella	04.00				4.620	280.30 (245.90)
72125	X-ray of the right knee including patella	04.00				4.620	280.30 (245.90)
Ankle and Foot							
	Code 74145 (toe) may not be combined with 74120 or 74125 (foot). Code 71450 (sesamoid bones) may be combined with 74120 or 74125 (foot) if requested. Codes 74120 and 74125 (foot) may only be combined with 74130 and 74135 (calcaneus) if specifically requested. Code 74160 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 74170 (introduction of contrast) may be combined with 74300 and 74305 (CT) or 74400 and 74405 (MR). The combination of 74160 (arthrography) and 74300 and 74305 (CT) or 74400 and 74405 (MR) are not supported except in exceptional circumstances with motivation.					04.00	
74100	X-ray of the left ankle	04.00				3.320	201.40 (176.70)
74105	X-ray of the right ankle	04.00				3.320	201.40 (176.70)
74120	X-ray of the left foot	04.00				2.800	169.90 (149.00)
74125	X-ray of the right foot	04.00				2.800	169.90 (149.00)
Thorax							
82600	Chest drain insertion	04.00				8.820	535.00 (469.30)
82605	Trachial, bronchial stent insertion	04.00				30.360	1841.70 (1615.50)
Gastrointestinal							
83600	Oesophageal stent insertion	04.00				31.220	1893.90 (1661.30)
83605	GIT balloon dilation	04.00				24.360	1477.70 (1296.20)
83615	Percutaneous gastrostomy, jejunostomy	04.00				25.360	1538.40 (1349.50)

SERVICES BY RADIOGRAPHERS

DIAGNOSTIC PROCEDURES

Note : Items 015, 029, 031, 033, 037, 065, 071, 073, 075, 077, 079, 081, 083, 085, 087, 089, 091, 093, 095, 097, 099, 101, 115, 117, 119, 121, 129, 131, 133, 135, 137, 139, 141, 149, 167, 171 and 173 shall only be paid on condition that the radiographer submits the name of the supervising clinician and his/her BHF practice number. The Fund shall not pay the radiographer if she/he is supervised by a radiologist.

GENERAL RULES

1000	When drugs, consumables and disposable items are used during a procedure, or issued to a patient on discharge, the Fund shall only reimburse the cost of such items, in line with this tariff, if the appropriate code is supplied on the account				04.00

MODIFIERS

0001	The specified call-out fee may be charged for any bona-fide, justifiable emergency occurring at any hour which requires the practitioner to travel to the patient. The Fund may require a motivation to accompany the claim.	06.02		12.490	31.84 (27.93)
0021	Services rendered to hospital patients: Quote modifier 0021 on all accounts for services performed on hospital or day clinic patients.				04.00
0080	Multiple examinations: Full fees				04.00
0084	Films should be charged under code 300.				06.02

Code	Description	Ver	Add	Radiography RVU	Radiography Fee
1	**SKELETON**				
1.1	**LIMBS**				
003	Limb per region, e.g. shoulder, elbow, knee, foot, hand, wrist or ankle (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	04.00		16.200	41.30 (36.20)
1.2	**SPINAL COLUMN**				
017	Per region, e.g. cervical, sacral, coccygeal, one region thoracic	04.00		24.600	62.70 (55.00)
027	Pelvis (sacro-iliac or hip joints only to be added where an extra set of views is required)	04.00		17.000	43.30 (38.00)
	MYELOGRAPHY				
029	Lumbar	04.00		43.100	109.90 (96.40)
031	Thoracic	04.00		40.100	102.20 (89.60)
033	Cervical	04.00		59.400	151.40 (132.80)
035	Multiple (lumbar, thoracic, cervical): Same fee as for first segment (no additional introduction of contrast medium)	04.00		-	-
1.3	**SKULL**				
039	Skull studies	04.00		32.300	82.30 (72.20)
043	Facial bones and/or orbits	04.00		34.900	89.00 (78.10)
045	Mandible	04.00		26.000	66.30 (58.20)
047	Nasal bone	04.00		16.200	41.30 (36.20)
049	Mastoid: Bilateral	04.00		50.000	127.50 (111.80)

CHEST					
105	Larynx (tomography included)	04.00		42.400	108.10 (94.80)
107	Chest (item 167 included)	04.00		19.200	48.90 (42.90)
109	Chest and cardiac studies (item 167 included)	04.00		23.100	58.90 (51.70)
BRONCHOGRAPHY					
115	Unilateral	04.00		33.500	85.40 (74.90)
117	Bilateral	04.00		56.500	144.00 (126.30)
119	Pleurography	04.00		15.700	40.00 (35.10)
121	Laryngography	04.00		15.700	40.00 (35.10)
123	Thoracic inlet	04.00		15.700	40.00 (35.10)
2	**ABDOMEN**				
125	Control films of the abdomen (not being part of examination for barium meal, barium enema, pyelogram, cholecystogram, cholangiogram, etc.)	04.00		17.000	43.30 (38.00)
127	Acute abdomen or equivalent studies	04.00		30.700	78.30 (68.70)
3	**GYNAECOLOGY AND OBSTETRICS**				
145	Pregnancy	04.00		19.200	48.90 (42.90)
4	**COMPUTED TOMOGRAPHY**				
155	Head, single examination, full series	04.00		262.700	669.60 (587.40)
157	Head, repeat examination at the same visit, after contrast, full series	04.00		90.200	229.90 (201.70)
159	Chest	04.00		303.700	774.10 (679.00)
161	Abdomen (including base of chest and/or pelvis)	04.00		353.000	899.80 (789.30)
MODIFIER GOVERNING THIS SPECIFIC SECTION OF THE TARIFFS					
0089	The number of sections of each examination and the matrix number must be specified. A full series of sections would be 8 or more for brain examinations, 12 or more for chest examinations and 16 or more for abdomen examinations. Fees for examinations on a matrix number of less than 250 shall be reduced by 50%				04.00
5	**MISCELLANEOUS**				
167	Fluoroscopy: Per half hour: Add (not applicable to items 107 and 109)	04.00		21.400	54.50 (47.80)
169	Where a C-arm portable x-ray unit is used in hospital or theatre: Per half hour: Add	04.00		29.600	75.50 (66.20)
179	Attendance at operation in theatre or at radiological procedure performed by a surgeon or physician in x-ray department except 005: Per 1/2 hour: Plus fee for examination performed	04.00		17.600	44.90 (39.40)
181	Setting of sterile trays	04.00		3.000	7.65 (6.71)

	Films are to be charged (exclusive of VAT) at net acquisition price plus - * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.	06.02			
300	X-Ray films	06.02			
ATTENDANCE IN CATHETERISATION LABORATORY					
	Use codes 191 to 193 to charge for radiographer input where that is not included in cath lab facility fee				04.00
191	Preparation in catheterisation laboratory for purposes of cardiac catheterisation and/or invasive intravascular procedures.	04.00		43.000	109.60 (96.10)
192	Post-processing in catheterisation laboratory for purposes of cardiac catheterisation and/or invasive intravascular procedures	04.00		43.000	109.60 (96.10)
193	Coronary angiogram per 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		43.000	109.60 (96.10)
215	Embolisation per 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		43.000	109.60 (96.10)
RULES					
Z	No fee to be subject to more than one reduction				04.00
6	**PORTABLE UNIT EXAMINATIONS**				
185	Where portable x-ray unit is used in the hospital or theatre: Add	04.00		19.400	49.50 (43.40)
187	Theatre investigations with fixed installation : Add	04.00		8.300	21.20 (18.60)

SERVICES OF PHYSIOTHERAPISTS		
REGULATIONS DEFINING THE SCOPE OF THE PROFESSION OF PHYSIOTHERAPY (R2301 - 3 December 1976)		
SCHEDULE		
General rules governing the tariff		
002	In exceptional cases where the fee is disproportionately low in relation to the actual services rendered by the practitioner, the practitioner shall provide motivation for a higher fee and such higher fee as may be agreed upon between the practitioner and the Fund may be charged	04.00
003	Where a practitioner uses equipment which is not owned by that practitioner, a reduction of 15% of the relevant rate will be applicable. Modifier 0003 must be quoted when this rule is applied	04.00
004	In the case of prolonged or costly treatment, the practitioner should first ascertain from the Fund whether it will accept financial responsibility in respect of such treatment	04.00
005	After a series of 20 treatments in respect of one patient for the same condition, the practitioner concerned shall report to the Fund as soon as possible if further treatment is necessary. Payment for treatments in excess of the stipulated number may be granted by the Fund after receipt of a letter from the practitioner concerned, motivating the need for such treatment	04.00
006	Where emergency treatment is provided: a. during working hours, and the provision of such treatment requires the practitioner to leave her or his practice to attend to the patient in hospital; or b. after working hours the fee for such visits shall be the total fee plus 50%. For purposes of this rule: a. "emergency treatment" means a bona fide, justifiable emergency physiotherapy procedure, where failure to provide the procedure immediately would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy; and b. "working hours" means 8h00 to 17h00, Monday to Friday. Modifier 0006 must be quoted after the appropriate code number(s) to indicate that this rule is applicable.	04.00
007	Practitioners are reminded that a lower fee than that appearing in the tariff shall be charged if the customary fee in the area is less than that charged. Reduced fees shall also be charged where the practitioner would have reduced his/her fee in private practice in particular cases. Prolonged treatment or exceptional cases should also receive special consideration in accordance with the usual medical practice	04.00
008	The fee in respect of more than one procedure (excluding evaluation and visiting items 407, 501, 502, 503, 507, 509, 701, 702, 703, 704, 705, 706, 707, 708, 801, 803, 901 and 903) performed at the same consultation or visit, shall be the fee for the major procedure plus half the fee in respect of each additional procedure, but under no circumstances may fees be charged for more than three procedures carried out in the treatment of any one condition. Modifier 0008 must then be quoted after the appropriate code numbers for the additional code numbers for the additional procedures to indicate that this rule is applicable.	05.05
009	When more than one condition requires treatment and each of these conditions necessitates an individual treatment, they shall be charged as individual treatments. Full details of the nature of the treatments and the diagnosis or diagnostic codes shall be stated. Modifier 0009 must then be quoted after the appropriate code number to indicate that this rule is applicable.	04.00
010	When the treatment times of two completely separate and different conditions overlap, the fee shall be the full fee for one condition and 50% of the fee for the other condition. Both conditions must be specified. Modifier 0010 must then be quoted after the appropriate code number to indicate that this rule is applicable.	04.00

011	Every physiotherapist must acquaint himself with the provisions of the Medical Schemes Act, 1998 and the regulations promulgated under the Act in connection with the rendering of accounts. Every account shall contain the following particulars : · The name and practice code number of the referring practitioner (where applicable). · The name of the patient. · The practice code number and name of practitioner · The nature and cost of the treatment. · The date on which the service was rendered. · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.	04.00
012	Where the physiotherapist performs treatment away from the treatment rooms, travelling costs being more than 16 kilometres in total) to be charged according to the AA-rate. Modifier 0013 must be quoted after the appropriate code numbers to show that this rule is applicable.	04.00
013	Physiotherapy services rendered in a nursing home or hospital. Modifier 0014 must be quoted after each code.	04.00
014	When drugs, consumables and disposable items are used during a procedure, or issued to a patient on discharge, the Fund shall only reimburse the cost of such items, in line with this tariff, if the appropriate code is supplied on the account.	04.00

Modifiers		
0001	Appointment not kept	04.00
0003	15% of the relevant rate to be deducted where equipment used is not owned by the practitioner	04.00
0006	Add 50% of the total fee for the treatment	04.00
0008	Only 50% of the fee for these additional procedures may be charged	04.00
0009	The full fee for the additional condition may be charged	04.00
0010	Only 50% of the fee for the second condition may be charged	04.00
0013	Travelling costs (being more than 16 kilometres in total) according to AA-rate.	04.00
0014	Physiotherapy services rendered to an in-patient in a nursing home or hospital.	04.00

1	**RADIATION THERAPY / MOIST HEAT / CRYOTHERAPY**				
Code	**Description**	**Ver**	**Add**	**Physiotherapy**	
				RVU	**Fee**
001	Infra-red, Radiant heat, Wax therapy Hot packs	04.00		5.000	24.10 (21.10)
005	Ultraviolet light	04.00		10.000	48.20 (42.30)
006	Laser beam	04.00		15.000	72.30 (63.40)
007	Cryotherapy	04.00		5.000	24.10 (21.10)
2	**PHYSICAL MODALITIES**				
300	Vibration	04.00		10.000	48.20 (42.30)
301	Percussion	04.00		16.100	77.60 (68.10)
302	Massage	04.00		10.000	48.20 (42.30)
307	Pre- and post-operative breathing exercises	04.00		10.000	48.20 (42.30)
318	Upper respiratory nebulisation and/or lavage	04.00		10.000	48.20 (42.30)
319	Nebulisation	04.00		10.000	48.20 (42.30)

321	Intermittent positive pressure ventilation.	04.00		10.000	48.20 (42.30)
323	Suction: Level 1 (including sputum specimen taken by suction)	04.00		5.000	24.10 (21.10)
325	Suction: Level 2 (Suction with involvement of lavage as a treatment in a special unit situation or in the respiratory compromised patient)	04.00		20.090	96.90 (85.00)
327	Bagging (used on the intubated unconscious patient or in the severely respiratory distressed patient).	04.00		5.000	24.10 (21.10)
3	**OTHER**				
117	Appointment not kept (the Fund will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the Fund" or "Patient own account" category).	04.00		-	-
937	Bird or equivalent freestanding nebuliser excluding oxygen at hospital per day.	04.00		10.000	48.20 (42.30)
939	Cost of material: Items to be charged (exclusive of VAT) at net acquisition price plus - 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.	04.00		-	-
940	Cost of appliances: Items to be charged (exclusive of VAT) at net acquisition price plus- 26% of the net acquisition price where the net acquisition price of that appliance is less than one hundred rands; a maximum of twenty six rands where the net acquisition price of that appliance is greater than or equal to one hundred rands.	04.00		-	-
941	Hiring equipment: 1% of the current replacement value of the equipment per day. Total charge not to exceed 50% of replacement value. Description of equipment to be supplied.	04.00			
	Payment of this item is at the discretion of the Fund, and should be considered in instances where cost savings can be achieved. By prior arrangement with the Fund	05.03			

SERVICES BY OCCUPATIONAL AND ART THERAPISTS		
REGULATIONS DEFINING THE SCOPE OF THE PROFESSION OF OCCUPATIONAL THERAPY (R2145 - 31 July 1992)		
GENERAL RULES		
006	Where emergency treatment is provided: a. during working hours, and the provision of such treatment requires the practitioner to leave her or his practice to attend to the patient in hospital; or b. after working hours the fee for such visits shall be the total fee plus 50%. For purposes of this rule: a. "emergency treatment" means a bona fide, justifiable emergency occupational therapy procedure, where failure to provide the procedure immediately would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy; and b. "working hours" means 8h00 to 17h00, Monday to Friday. Modifier 0006 must be quoted after the appropriate code number(s) to indicate that this rule is applicable. Rule 006 does not apply to art therapy.	05.02
008	The provision of assistive devices shall be charged (exclusive of VAT) at net acquisition price plus – - 26% of the net acquisition price where the net acquisition price of that appliance is less than one hundred rands; - a maximum of twenty six rands where the net acquisition price of that appliance is greater than or equal to one hundred rands. Modifier 0008 must be quoted after the appropriate code numbers to show that this rule is applicable.	04.00
009	Materials used in the construction of orthoses or pressure garments shall be charged (exclusive of VAT) at net acquisition price plus - - 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; - a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands. Modifier 0009 must be quoted after the appropriate code numbers to show that this rule is applicable. Rule 009 does not apply to art therapy.	04.00
010	Materials used in treatment shall be charged (exclusive of VAT) at net acquisition price plus - - 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; - a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands. Modifier 0010 must be quoted after the appropriate code numbers to show that this rule is applicable.	04.00
011	Where the therapist performs treatments away from the treatment rooms, travelling costs to be charged according to AA rates e.g. for domiciliary treatments or treatments in nursing homes. Modifier 0011 must be quoted after the appropriate code numbers to show that this rule is applicable.	04.00

012	Every practitioner shall render a monthly account in respect of any service rendered during the month, irrespective of whether or not the treatment has been completed. NB. Every account shall contain the following particulars: i The name and practice number of the consulting occupational or art therapist. ii The name of the patient/ claimant. iii The reference number of the patient/ claimant. iv The nature of the treatment. v The date on which the service was rendered. vi The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.	05.02
013	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge shall only be reimbursed by the Fund if the appropriate code is supplied on the account. Please note: In the case of occupational therapy, a code will only be required when a standard proprietary (off the shelf) product is used. When a splint or support is made by the occupational therapist using or modifying one or more components, a code cannot accurately identify this non-standard product. Please refer to annexure itemising the most commonly made non-standard products used in occupational therapy and bill accordingly. The Occupational Therapy Association of S A has made available a generic list of non-proprietary splints and pressure garments commonly made by practitioners. The type of materials used to manufacture these products is at the discretion of the practitioner concerned. Price of splints and pressure garments may vary. See Annexures A & B.	04.00

Modifiers

0006	Add 50% of the total fee for the procedure. Modifier 0006 does not apply to art therapy.	04.00
0008	Assistive devices to be charged (exclusive of VAT) at net acquisition price plus – - 26% of the net acquisition price where the net acquisition price of that appliance is less than one hundred rands; - a maximum of twenty six rands where the net acquisition price of that appliance is greater than or equal to one hundred rands.	04.00
0009	Materials used for orthoses or pressure garments to be charged (exclusive of VAT) at net acquisition price plus - - 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; - a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands. See Annexures A & B for non-standard products. Modifier 0009 does not apply to art therapy.	05.02
0010	Materials used in treatment to be charged (exclusive of VAT) at net acquisition price plus - - 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; - a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.	04.00
0011	Travelling costs according to AA rates.	04.00

0021	Services rendered to hospital inpatients: Quote modifier 0021 on all accounts for services performed on hospital inpatients.				04.00		
ITEMS							
1	**PROCEDURES OF INTERVIEWING, GUIDANCE AND CONSULTANCY**						
Code	**Description**	**Ver**	**Add**	**Occupational Therapy**		**Arts Therapy**	
				RVU	**Fee**	**RVU**	**Fee**
108	Interview, guidance or consultation: 30 minute duration.	06.02		21.250	107.60 (94.40)	21.250	58.90 (51.70)
109	Interview, guidance or consultation. Each additional 15 mins. A maximum of four instances of this code may be charged per session.	06.02	+	10.630	53.80 (47.20)	10.625	29.40 (25.80)
	Time based items in this section exclude time spent on procedures charged in addition to the consultation	05.02					
107	Appointment not kept (fund will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the fund" or "Patient own account" category).	04.00		-	-	-	-
110	Reports. To be used to motivate for therapy and/or give a progress report and/or a pre-authorisation report, where such a report is specifically required by the Fund.	05.02		16.500	83.50 (73.20)	22.140	61.30 (53.80)
2	**PROCEDURES OF INITIAL EVALUATION TO DETERMINE THE TREATMENT.**						
215	A dynamic orthosis.	04.00		7.500	38.00 (33.30)		
217	A pressure garment for one limb.	04.00		7.500	38.00 (33.30)		
221	A pressure garment for the trunk.	04.00		7.500	38.00 (33.30)		
3 List of splints and pressure garments exempted from NAPPI codes							
Annexure A							
	Numbers and names of splints to be used with modifier 0009						04.00
701	Static finger extension/flexion splint	04.11		-	-		
702	Dynamic finger extension/flexion	04.11		-	-		
706	Hand based static finger extension/flexion	04.00		-	-		
707	Hand based static thumb extension/flexion/opposition/ abduction	04.00		-	-		
708	Hand based dynamic finger flexion/extension	04.00		-	-		
709	Hand based dynamic thumb flexion/extension/opposition/abduction	04.00		-	-		
710	Static wrist extension/flexion	04.00		-	-		
711	Dynamic wrist extension/flexion	04.00		-	-		
713	Forearm based dynamic finger flexion/extension	04.00		-	-		
714	Forearm based dorsal protection	04.00		-	-		
715	Forearm based volar resting	04.00		-	-		
716	Static elbow extension/flexion	04.00		-	-		
717	Dynamic elbow flexion/extension splint	04.00		-	-		

718	Shoulder abduction splint	04.00		-	-		
719	Static rigid neck splint	04.00		-	-		
720	Static soft neck splint/brace	04.00		-	-		
721	Static knee extension	04.00		-	-		
722	Static foot dorsiflexion	04.00		-	-		
Annexure B							
	Numbers and names of pressure garments to be used with modifier 0009						04.00
801	Glove to wrist	04.00		-	-		
802	Glove to elbow	04.00		-	-		
803	Gauntlet (Glove with palm and thumb only)	04.00		-	-		
804	Sleeve: Upper/forearm	04.00		-	-		
805	Sleeve: full	04.00		-	-		
806	Vest + sleeves	04.00		-	-		

SERVICES BY CLINICAL TECHNOLOGISTS

GENERAL RULES

001	When drugs, consumables and disposable items are used during a procedure, or issued to a patient on discharge, the Fund shall only reimburse the cost of such items, in line with this tariff, if the appropriate code is supplied on the account.	04.00

MODIFIERS

0001	Fee prorated according to number of treatment days;. fee = ([number of treatment days] / 30) X (item fee)	05.03

ITEMS

Surgical Support

Code	Description	Ver	Add	Clinical Technology	
				RVU	Fee
010	Ablations	04.00		219.700	1508.00 (1322.80)
011	Preparation of extra-corporeal equipment for surgical procedures.	04.00		196.700	1350.10 (1184.30)
012	Operation of heart laser during myocardial revascularisation	04.00		219.700	1508.00 (1322.80)
013	Continued operation of extra-corporeal equipment during surgery for a time in excess of one hour in 30 minute increments or part thereof provided that such part comprises 50% or more of the time	04.00		20.300	139.30 (122.20)
014	Radiofrequency Catheter Ablations	04.00		219.700	1508.00 (1322.80)

	Not to be charged with item 012	05.03			
015	Preparation and operation of pre-operative, intra-operative or post operative physiological monitoring per patient, per admission	04.00		19.400	133.20 (116.80)
	May only submit once in theatre and once in catheterisation laboratory	05.03			
017	Standby with extra-corporeal equipment for surgery within hospital	04.00		58.800	403.60 (354.00)
	Cannot be used with 011	05.03			
019	Standby within the hospital for coronary angioplasty.	04.00		19.400	133.20 (116.80)
021	Preparation and operation of intra-aortic balloon pump in theatre, intensive care unit and catheterisation laboratory.	04.00		58.800	403.60 (354.00)
085	Each additional 30 minutes or part thereof, provided that such part comprises 50% or more of the time.	04.00		10.000	68.60 (60.20)
023	Global fee for preparation and operation and removal of cardio assist device (LVAD, RVAD, BVAD) in theatre and intensive care unit.	04.00		196.700	1350.10 (1184.30)
027	Preparation and operation of a pre- and post-operative blood salvage device.	04.00		19.400	133.20 (116.80)
029	Preparation and operation of an autotransfusion cell washing system.	04.00		77.100	529.20 (464.20)
031	Determination and monitoring of haemodynamic/pulmonary parameters, metabolism, arterial/venous pressure flow studies in high care/ICU (per patient per multiple procedures per day)	04.00		61.700	423.50 (371.50)
033	Assistance with bronchoscopy procedures, placement of arterial/venous catheters, ultrasound examinations or photography.	04.00		14.600	100.20 (87.90)
034	Lymph compression treatment.	04.00		22.500	154.40 (135.40)
116	Preparation and operation of an artificial heart (Berlin-Heart)	04.00		219.700	1508.00 (1322.80)
118	Daily monitoring of artificial heart, per hour	04.00		33.400	229.30 (201.10)
157	Standby with extra corporeal equipment (maximum 4 hours) (per event).	04.00		26.300	180.50 (158.30)
Pulmonology					
	Items 035 to 061 apply only to outpatient department and normal wards - Not high care or intensive care, except item 050 which applies to intensive care only.				04.00
035	Nebulization (per one procedure).	04.00		12.300	84.40 (74.00)
037	Measurement of Lung volumes and capacities by means of closed circuit (He) or (N2) washout or body plethysmography.	04.00		24.200	166.10 (145.70)

039	Flow-volume determinations.	04.00		30.600	210.00 (184.20)
041	Flow-volume (Pre-post B-D).	04.00		50.800	348.70 (305.90)
043	Airways resistance and conductance measurements using plethysmograph or similar apparatus.	04.00		24.200	166.10 (145.70)
045	Gas distribution measurements.	04.00		24.200	166.10 (145.70)
047	Diffusion determinations.	04.00		24.200	166.10 (145.70)
050	ECMO change-out and re-establishment.	04.00		46.300	317.80 (278.80)
Cardiology					
062	Assist in preparations and operations of Rotablator Procedures	04.00		29.900	205.20 (180.00)
063	Cardiac catheterisation for the first hour.	04.00		40.300	276.60 (242.60)
065	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		10.000	68.60 (60.20)
064	Intravascular Ultrasound (IVUS)	04.00		25.700	176.40 (154.70)
	This fee can only be charged once, irrespective of how many times this procedure is repeated. The technologist cannot charge for this procedure if a representative of a company or any other person is operating the IVUS machine	05.03			
068	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time.	04.00		10.000	68.60 (60.20)
066	Cardiac Cath Right Heart Studies	04.00		56.000	384.40 (337.20)
067	Cardiac Electro physiology and related procedures for first FOUR hours.	04.00		67.900	466.10 (408.90)
Dialysis					
145	Preparation of extra-corporeal equipment: Haemoperfusion (HP), Haemofiltration (HF), Haemoconcentration (HC), Continuous renal replacement therapy (CRRT), Aphaeresis, Auto transfusion and cell recovery (AT).	04.00		46.300	317.80 (278.80)
147	Peritoneal dialysis, per day	04.00		16.800	115.30 (101.10)

	The global fees for Continuous Ambulatory Peritoneal Dialysis (CAPD) (Item 176) and Automated Peritoneal Dialysis (APD) (Item 177) include: consumables; cost of machine and machine disposables; professional fee; initial training; in-centre follow-up visits; and home visits. However, they exclude Tenckhoff catheter and insertion thereof; and disposables required for a transfer set change (usually 6 monthly). These fees are chargeable for each 30 day cycle in which CAPD or APD is provided. If CAPD or APD is provided for less than a 30 days in any one cycle (for example due to complications or death of the patient): a. if the period of treatment is 26 days or more in that cycle, the full fee applies; b. if the period of treatment is up to 25 days in that cycle, the fee should be prorated according to number of actual treatment days. Modifier 0001 should be quoted, and number of treatment days specified.	05.03			
151	Treatment procedures for CRRT up to 6 hours or part thereof provided that such part comprises 50% or more of the time	04.00		24.800	170.20 (149.30)
152	Treatment procedure for CRRT up to 12 hours or part thereof provided that such part comprises more than 6 hours of the time	04.00		49.700	341.10 (299.20)
154	Treatment procedure for CRRT up to 18 hours or part thereof provided that such part comprises more than 12 hours of the time	04.00		74.500	511.40 (448.60)
156	Treatment procedure for CRRT up to 24 hours or part thereof provided that such part comprises more than 18 hours of the time	04.00		99.300	681.60 (597.90)
Miscellaneous					
171	Travelling per km in excess of 16km (in own car).	04.00		0.675	4.63 (4.06)
173	Equipment hire (By arrangement with the Fund).	04.00		-	-
175	Medication / Material	04.00		-	-
	The amount charged in respect of medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965). In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus - * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.	05.03			

ANNEXURE B

FORMS

RAF 1

CLAIM FOR COMPENSATION AND MEDICAL REPORT

(SECTIONS 17(1) AND 24(1)(*a*) OF ACT NO. 56 OF 1996 AND REGULATION 9(1) OF THE REGULATIONS UNDER THE ACT)

1) A separate form must be completed and lodged with regard to each injured or deceased person in respect of whose bodily injury or death compensation is claimed.

2) In order for the Fund to be able to deal with this claim expeditiously it is essential that all the required supporting vouchers and statements should accompany this form and in the case of item 6 of this form it is desirable also to-
(a) attach all medico-legal reports in the possession of the claimant; and
(*b*) indicate, with regard to a claim for future loss of earnings, on a separate statement how such loss is calculated.

3) Written authority for inspection by or on behalf of the Fund of all records regarding the injured or deceased person which may be in the possession of any hospital or medical practitioner must accompany this form.

4) Items 1 to 4 of this form must be completed before this form is submitted to the medical practitioner for completion of the medical report.

5) The liability of the Fund to pay hospital, medical and related expenses is limited to one of two tariffs, the one tariff being applicable in cases of emergency medical treatment and the other being the UPFS, as provided for under regulation 5 of the Regulations under the Act.

6) The liability of the Fund for non-pecuniary loss is limited to injuries which after assessment, in accordance with the method prescribed under regulation 3 of the Regulations under the Act, are assessed to be serious.

7) If required, please contact the Fund to assist you with the completion of the form and with the lodgment of your claim directly with the Fund.

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1. **PARTICULARS OF THE CLAIMANT**

Name(s)	
Surname	
ID Number / Passport Number	
Citizenship	
Telephone number / Cell number	
Facsimile number	
E-mail address	
Physical address	
Postal address	
Capacity in which claiming (i.e. self, guardian, *curator ad litem*)	
Banking details for purposes of payment by the Road Accident Fund	
Name and surname of account holder	
Bank name	
Branch name	
Bank account number	
Branch code	
Account type	

2. **PARTICULARS OF THE MOTOR VEHICLE FROM THE DRIVING OF WHICH THIS CLAIM ARISES**

Registration number	
Particulars of the driver of the motor vehicle	
Name(s) and surname	
Physical address	

Postal address	
Telephone number / Cell number	
Particulars of the owner of the motor vehicle, where the owner was not the driver	
Name(s) and surname	
Physical address	
Postal address	
Telephone number / Cell number	
NOTE: If the identity of neither the owner nor the driver has been established, attach a separate statement stating any additional information regarding the vehicle and describe what steps were taken to establish the identity of the owner or driver of the vehicle.	

3. **PARTICULARS OF THE ACCIDENT**

What was the date of the accident?	
What was the time of the accident?	
Where did the accident take place?	
At which police station was the accident reported?	
What is the police reference number?	
State whether the injured / deceased was a driver, passenger, cyclist or pedestrian -	
Where applicable, state the registration number of the vehicle of which the injured / deceased was the driver; alternatively on, or in, which the injured / deceased was a passenger -	
NOTE: Attach an affidavit (supported by a rough sketch of the scene of the accident) in which particulars of the accident are fully set out, and attach copies of all available statements (including eyewitness accounts) and related documents (including the police accident report and plan).	
Particulars of any other motor vehicles involved in the accident -	
Registration number	
Name(s) and surname of driver	
Physical address	
Postal address	
Telephone number / Cell number	
NOTE: If more than two vehicles were involved in the accident set out the above particulars of the other vehicles involved in an annexure to this claim form.	

4. **PARTICULARS OF THE INJURED OR DECEASED**

NOTE: Where the claimant is also the injured the particulars required hereunder *need not be* furnished again – in all other instances the particulars *must* be furnished.	
Name(s)	
Surname	
ID Number / Passport Number	
Citizenship	
Telephone number / Cell number	
Facsimile number	
E-mail address	
Physical address	
Postal address	
NOTE: The particulars hereunder *must* be furnished in all instances, including instances where the claimant is also the injured.	
Marital status (i.e. married, divorced, single, etc.)	
Business or occupation	
Name of employer	
Postal address of employer	
Telephone / Cell number of employer	

Facsimile number of employer	
State the income of the injured / deceased for the 12 months immediately preceding the accident	R
Was the injured or deceased injured in the course of his / her employment?	
Where the injured is entitled to, or has received, compensation under the Compensation for Occupational Injuries Act, 1993, state-	
The Compensation Commissioner's reference number, if known	
What amount has been received	R

5. PARTICULARS OF DEPENDANTS WHERE LOSS OF SUPPORT IS CLAIMED

NOTE: Where the claimant is also a dependant the particulars required hereunder *need not be* furnished again – in respect of the other dependants the particulars *must* be furnished.	
Name(s)	
Surname	
ID Number / Passport Number	
Citizenship	
Telephone number / Cell number	
Facsimile number	
E-mail address	
Physical address	
Postal address	
NOTE: The particulars hereunder *must* be furnished in all instances, including instances where the claimant is also a dependant.	
Relationship to deceased (i.e. wife, son, daughter, etc.)	
Marital status (i.e. married, divorced, single, etc.)	
Business or occupation	
Name of employer	
Postal address of employer	
Telephone number of employer	
Facsimile number of employer	
Income for 12 months immediately preceding the accident	R
Where the deceased's dependant(s) are entitled to, or have received ,compensation under the Compensation for Occupational Injuries Act, 1993, state-	
The Compensation Commissioner's reference number	
What amount has been received	R

6. PARTICULARS OF THE COMPENSATION CLAIMED

Hospital expenses	R
Medical expenses	R
Estimated future medical expenses	R
Past loss of income	R
Future loss of income	R
Past loss of support	R
Future loss of support	R
Funeral expenses	R
Non-pecuniary loss	R
Total amount claimed	R

7. DECLARATION

I hereby declare that to the best of my knowledge and belief the information set out in this form is true and correct in every respect

Signature of claimant, as per item 1 above (alternatively the signature of the claimant's authorised legal representative, in which case a written special power of attorney must accompany this claim form)	..... Signature of claimant / legal representative
Signature of witness	..... Witness
Signature of witness	..... Witness

Signed at	.....
Date	.....

MEDICAL REPORT

1) Section 24(2)(*a*) provides that this report shall be completed by the medical practitioner who treated the injured or deceased person for the bodily injuries sustained by him/her in the accident from which this claim arises or by the superintendent (or his/her representative) of the hospital in which the injured or deceased person was treated for such bodily injuries.

1. **DETAILS OF PATIENT**

Name(s)	
Surname	
ID number / passport number / date of birth	
Are you satisfied that the patient is the person mentioned under item 4 (four) of the claim form?	

2. **PATIENT'S MEDICAL HISTORY AND PROGNOSIS**

Date when first seen after the accident	
Did you treat the patient at any time before the accident? If so, state the date of the last treatment and the nature of the ailment -	

Indicate, with a "X", which body part(s) sustained an injury(ies) and the degree of such injury(ies), also state the applicable ICD Code(s)-

Body Part	Head	Chest	Neck	Abdomen	Back	Upper Limbs	Lower Limbs	Pelvis
ICD - 10 Code(s)								

State full details of the nature of the injuries and any complications (e.g. fractured ribs with haemothorax, compound fracture left tibia, disfigurement, etc.) and state treatment given-

Has the patient's condition stabilized? If not, furnish details -	
Is any permanent disability expected? If so, furnish details -	
Is specialist treatment being given? If so, state the name and address of the specialist, where such treatment is being given -	
If the patient is employed state when return to employment is expected -	

Where future medical treatment is foreseen, state -

In respect of which injuries	
Probable nature of treatment	
Expected duration of treatment	
Estimated cost of treatment	R
If hospitalisation is foreseen	
Expected date of such hospitalization, if foreseen	
Expected duration of hospitalisation, if foreseen	

Has the injury(ies) aggravated any pre-existing pathological condition or has any such pre-existing condition aggravated the effects of trauma (furnish full details)-

Where the patient has been confined to a hospital / nursing home or other facility state -	
Name and address of the institution	
Patient's hospital / other reference number	
Date discharged / discharge expected	
In the case where the patient died state -	
Date of death	
Whether any pre-existing pathological condition contributed to the death? Furnish full details where applicable -	

3. MEDICAL PRACTITIONER'S DETAILS

Name	
Surname	
Qualifications	
Practice Number (HPCSA and/or BHF)	
Telephone number	
Facsimile number	
E-mail address	
Cell number	
Physical address	
Postal address	

4. DECLARATION

I hereby declare that to the best of my knowledge and belief the information set out in this form is true and correct in every respect.	
Signature of medical practitioner who's details are furnished in item 3 above and who completed this medical report	.....
Signed at	.....
Date	.....

RAF 3

ACCIDENT REPORT FORM

(SECTION 22(1)(a) OF ACT NO. 56 OF 1996 AND REGULATION 9(3) OF THE REGULATIONS UNDER THE ACT)

1) When any person has been injured or killed as a result of the driving of a motor vehicle, the owner and the driver of that motor vehicle must report that accident to the Fund on this form within 14 days, failing which the compensation paid to the third party may be recovered from that owner or driver.

Postage will be paid by the Addressee

No postage necessary if posted in the Republic of South Africa

CHIEF EXECUTIVE OFFICER
P O Box 2743
PRETORIA
0001

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1. PARTICULARS OF THE *DRIVER* OF THE VEHICLE

Name(s)	
Surname	
ID Number / Passport Number	
Citizenship	
Telephone number	
Facsimile number	
Cell number	
E-mail address	
Physical address	
Postal address	
Driver's License Number	
Date issued	
Endorsements, if any	
Physical / mental defects, if any	
State whether you are also the owner of the vehicle -	

2. **PARTICULARS OF THE *OWNER* OF THE VEHICLE - COMPLETE WHERE THE DRIVER WAS NOT THE OWNER**

Name(s)	
Surname	
ID Number / Passport Number	
Citizenship	
Telephone number	
Facsimile number	
Cell number	
E-mail address	
Physical address	
Postal address	

3. **PARTICULARS OF THE *MOTOR VEHICLE***

Registration number	
Body (i.e. sedan, truck, bus etc)	
Color	
Make	
Model	
Year	

4. **PARTICULARS OF *OTHER MOTOR VEHICLES* INVOLVED IN THE ACCIDENT**

Motor Vehicle	Vehicle 1	Vehicle 2	Vehicle 3
Registration number			
Name(s) and surname of driver			
Physical address			
Postal address			
Telephone number / Cell number			
Name(s) and surname of owner			
Physical address			
Postal address			
Telephone number / Cell number			
NOTE: If more vehicles were involved in the accident set out the above particulars of the other vehicles involved in an annexure to this claim form			

5. **PARTICULARS OF *THE ACCIDENT***

What was the date of the accident?	
What was the time of the accident?	
Where did the accident take place?	
At which police station was the accident reported?	
What is the police reference number?	

6. **PARTICULARS OF *WITNESS(ES)* TO THE ACCIDENT**

Witness	Witness 1	Witness 2	Witness 3
Name(s)			
Surname			
ID Number / Passport Number			
Telephone number			
Facsimile number			
Cell number			
E-mail address			

Physical address			
Postal address			

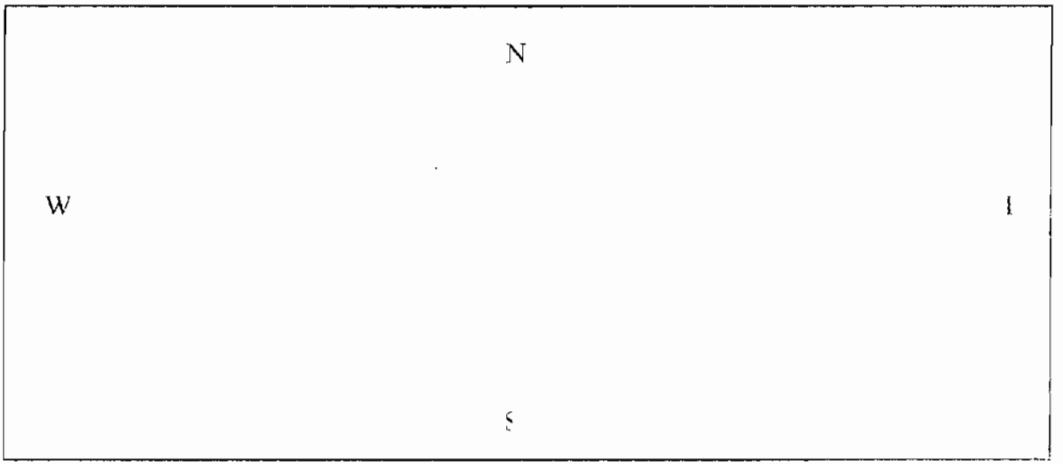
7. PARTICULARS OF PERSON(S) INJURED / DECEASED

Persons injured / deceased	Person 1	Person 2	Person 3
Name(s)			
Surname			
ID Number / Passport Number			
Telephone number			
Facsimile number			
Cell number			
E-mail address			
Physical address			
Postal address			
State whether the injured / deceased was a driver, passenger, cyclist or pedestrian -			
Where applicable, state the registration number of the vehicle of which the injured / deceased was the driver; alternatively on, or in, which the injured / deceased was a passenger -			

8. CONDITIONS AT THE TIME OF THE ACCIDENT

Time of day (i.e. dawn, day, dusk, night)	
Weather conditions (i.e. sunny, misty, cloudy, raining, etc.)	
Visibility (i.e. good, reasonable, bad, etc.)	
Road surface (i.e. gravel, sand, tar, etc.)	
Street lights - on or off	
Own vehicle's lights – off, dim, bright	
Other vehicle's lights – off, dim , bright	
Speed of own vehicle at time of accident	

9. SKETCH PLAN OF THE SCENE OF THE ACCIDENT



9. DETAILED DESCRIPTION OF THE ACCIDENT

10 DECLARATION

I / we hereby declare that to the best of my / our knowledge and belief the information set out in this form is true and correct in every respect

Signature of driver	..... Signature of driver
Signature of owner	..... Signature of owner (if not also the driver).
Signed at	.....
Date	.....