

Medical Practitioners 2004

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY MEDICAL PRACTITIONERS, EFFECTIVE FROM 1 JANUARY 2004

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.

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 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.

VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

RULES GOVERNING THE STRUCTURE

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.
B.	Normal hours and after hours: After-hours consultative services are paid at the same rate as benefits for normal hours consultative 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 0141-0144 or 0181-0185)
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
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
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
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 scheme 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
H.	Removal of lesions: Items involving removal of lesions include follow-up treatment for 10 days
J.	Disproportionately low fees: In exceptional cases where the fee is disproportionately low in relation to the actual services rendered by a medical practitioner, a higher fee may be negotiated. The use of this rule is not intended merely to increase the Medical Schemes Benefits.
K.	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. Medical practitioners referring cases to other medical practitioners shall indicate in the reference whether the patient is a member of a medical scheme or a dependant of such member. This also applies in respect of specimens sent to pathologists
L.	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
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
N.	"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
O.	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 medical scheme for what amount the medical scheme will accept responsibility in respect of such treatment, should the practitioner wish any direct payment from the scheme

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P.	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. Medical scheme benefits will not be applicable in such instances (Not applicable to COVID patients)
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 two 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)
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)
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.
T.	Ventilation (items 1212 to 1214) does not form a part of normal post-operative care, but may not be added to item 1204: Category 1: Cases requiring intensive monitoring
U.	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.
V.	(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
Y.	Except where otherwise indicated, radiologists are entitled to charge for contrast material used
Z.	No fee is subject to more than one reduction
AA.	Procedures to exclude cost of isotope
BB.	The fees in this section (radiation oncology) do NOT include the cost of radium or isotopes
CC.	Acupuncture: (a) When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately. (b) Not more than two separate techniques may be charged for at each session. (c) The maximum number of acupuncture treatments per course to be charged for is limited to 20. If further treatment is required at the end of this period of treatment, it should be negotiated with the patient. (d) Item 0380 refers to scalp acupuncture as a treatment in its own right and not to the use of acupuncture points on the scalp

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DD.	<p>*Use these values to multiply with the units in the NRPL-HS columns to obtain the national reference price for the item</p> <p>A Anaesthesiologists R30.24</p> <p>AC Anatomical Pathology - Cytology R 7.68</p> <p>AH Anatomical Pathology - Histology R 7.27</p> <p>CP Clinical Pathology R 6.66</p> <p>CL Clinical Procedures R 5.74</p> <p>CT Computed Tomography R 6.48</p> <p>V Consultative Services No RCF</p> <p>VP Consultative Services (Paediatrics and Paediatric No RCF Cardiologists)</p> <p>VG GP Consultative Services (0181 - 0185) No RCF</p> <p>HG Human Genetics R 6.82</p> <p>MR Magnetic Resonance Imaging R 6.21</p> <p>RO Radiation Oncology R 7.00</p> <p>RA Radiology R 8.16</p> <p>U Ultrasound R 5.49</p>
EE.	<p>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 of medical schemes 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 medical scheme 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</p>
FF.	<p>(a) When a cystoscopy precedes a related operation, Modifier 0013: Endoscopic examination done at an operation, applies, e.g. cystoscopy followed by transurethral (T U R) 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</p>
GG.	<p>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</p>
RR	<p>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.</p> <p>A separate radiology schedule is for the exclusive use of registered specialist radiology practices (Pr No "038") and nuclear medicine practices (Pr No "025").</p>
XX.	<p>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</p>
YY.	<p>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)</p>
MODIFIERS GOVERNING THE STRUCTURE	
0002	<p>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</p>
0004	<p>Procedures performed in own procedure rooms: Procedures performed in doctors' own procedure rooms instead of in a hospital theatre or unattached theatre unit: per fee for procedure + 100%. See Section V for a list of procedures, which are often done in rooms to which Modifier 0004 should not be applied. Please note: Modifier 0004 may only be charged by the medical practitioner owning the facility and the equipment. Only one person may claim this modifier for procedures performed in doctors' own procedure rooms</p>

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0005	<p>Multiple therapeutic procedures/operations under the same anaesthetic:</p> <p>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.</p> <p>b) In the case of multiple fractures and/or dislocations the above values shall prevail.</p> <p>c) When purely diagnostic endoscopic procedures or diagnostic endoscopic procedures unrelated to any therapeutic procedures performed, are performed under the same general anaesthetic, Modifier 0005 is not applicable to the fees for such diagnostic endoscopic procedures as the fees for endoscopic procedures do not provide for after-care. Specify unrelated endoscopic procedure and provide diagnosis to indicate diagnostic endoscopic procedure(s) unrelated to other (therapeutic) procedures performed under the same anaesthetic.</p> <p>d) Please note: When more than one small procedure is performed and the tariff makes provision for items for "subsequent" or "maximum for multiple additional procedures" (see Section 2. Integumentary System) Modifier 0005 is not applicable as the fee is already a reduced fee.</p> <p>e) "+" 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)</p>							
0006	<p>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</p>							
0007	<p>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.</p> <p>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</p>		15.00	R86.10	15.00	R86.10		
0008	<p>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</p>							
0009	<p>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</p>							
0010	<p>Local anaesthetic: (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</p>							
0011	<p>Emergency surgery for theatre procedures: Any bona fide, justifiable emergency procedure (all hours) undertaken in 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</p>							
0013	<p>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</p>							
0014	<p>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 plus an additional fee to be negotiated under general Rule J: In exceptional cases where the fee is disproportionately low in relation to actual service rendered, except where already specified in the tariff</p>							

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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							
0017	Injections administered by practitioners: When desensitization, intravenous, intramuscular or subcutaneous injections are administered by the practitioner himself to patients who attend the consulting rooms, a first injection forms a part of the consultation/visit and all subsequent injections for the same condition should be charged at 50% of the appropriate visit fee for a general practitioner		7.50	R43.05	7.50	R43.05		
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							
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							
0020	Conscious Sedation: Any case that is conducted outside of a theatre hospital suite shall be coded with the relevant procedure code. To identify these cases, the above modifier should be used to indicate to the medical funders that there will be no hospital/theatre account							
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 column) plus the time units (calculated according to the formula in Modifier 0023) and the appropriate modifiers (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							
0023	<p>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 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.</p> <p>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</p>							
0024	Pre-operative assessments not followed by procedures: If a pre-operative assessment of a patient by the anaesthesiologist 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							
0025	Calculation of anaesthetic time: Anaesthetic time is calculated from the time the anaesthesiologist 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 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 must show on his/her account the exact anaesthetic time, including the supervision time spent with the patient.							
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							
0028	Use of low flow anaesthetic technique less than 1 litre/minute: Fresh gas flow of less than 1 litre/minute. Additional R13,60 per 15 minutes of anaesthetic time. The amount reflected in this item would be reviewed regularly							
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							
0030	Use of low flow anaesthetic technique 1-2 litre/minute: Fresh gas flow of 1 to 2 litre/minute. Additional R7,20 per 15 minutes of anaesthetic time. The amount reflected in this item would be reviewed regularly							
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							
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							

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0033	Participating in general care of patients: When an anaesthesiologist 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 a specialist anaesthesiologist						
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						
0035	Anaesthetic administered by specialist anaesthesiologists: No anaesthetic administered by a specialist anaesthesiologist shall have a total value of less than 7,00 anaesthetic units (basic units, time units plus appropriate modifiers)						
0036	Fees for an anaesthetic administered by a general practitioner shall be two thirds (2/3) of the total number of units (basic plus time plus appropriate modifier) applicable to the specialist anaesthesiologist provided that no anaesthetic shall have a total value of less than 7.00 anaesthetic units. The monetary value of the unit is the same for both a specialist anaesthesiologist and a general practitioner anaesthesiologist.						
0037	Body hypothermia: Utilisation of total body hypothermia: Add 3,00 anaesthetic units					3.00	R90.72
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						
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						
0040	Pheochromocytoma: The basic anaesthetic units for procedures performed for pheochromocytoma shall be 15,00 anaesthetic units						
0041	Hyperbaric pressurisation: Utilisation of hyperbaric pressurisation: Add 3,00 anaesthetic units					3.00	R90.72
0042	Extracorporeal circulation: Utilisation of extracorporeal circulation: Add 3,00 anaesthetic units					3.00	R90.72
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					3.00	R90.72
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					3.00	R90.72
0045	<p>Post-operative alleviation of pain:</p> <p>(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</p> <p>(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.</p> <p>(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)</p>						
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						
0047	A fracture NOT requiring reduction shall be charged on a fee per service basis						
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)		27.00	R154.98	27.00	R154.98	
0049	Except where otherwise specified, in cases of compound fractures, 77,00 clinical procedure units are to be added to the units for the fractures including debridement		77.00	R441.98	77.00	R441.98	

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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)		115.50	R662.97	115.50	R662.97		
0051	Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting: Add 77,00 clinical procedure units.		77.00	R441.98	77.00	R441.98		
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		32.00	R183.68	32.00	R183.68		
0055	Dislocation requiring open reduction: Units for the specific joint plus 77,00 clinical procedure units.		77.00	R441.98	77.00	R441.98		
0057	Multiple procedures on feet: In multiple procedures on feet, fees for the first foot are calculated according to Modifier 0005: Multiple procedures/operations under the same anaesthetic. Calculate fees for the second foot in the same way, reduce the total to 75% and add to the total for the first foot							
0058	Revision operation for total joint replacement and immediate re-substitution (infected or non-infected): per fee for total joint replacement + 100%							
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							
0063	Where two specialists work together on a replantation procedure, each shall be entitled to two-thirds of the fee for the procedure							
0064	Where the replantation is unsuccessful, no further surgical fee is payable for amputation of the non-viable parts							
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							
0066	Microsurgery of the fallopian-tubes and ovaries: Where micro-surgical techniques are used, with the aid of a microscope, 25% may be added to the fee							
0067	Microsurgery of the larynx: Add 25% to the fee of the operation performed							
0069	When endoscopic instruments are used during intranasal surgery: Add 10% of the fee of the procedure performed. Only applicable to items 1025, 1027, 1030, 1033, 1035, 1036, 1039, 1047, 1054 and 1083							
0070	Add 45,00 clinical procedure units to procedure(s) performed through a thorascop		45.00	R258.30	45.00	R258.30		
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							
0073	When item 1288 or item 1289 performed by paediatric cardiologists ('33'): fee for procedure + 100%							
0074	A reduction of 33,33% (1/3) of the fee will apply to all fibre optic procedures performed by means of hospital equipment							
0075	The fee plus 21,00 clinical procedure units will apply where fibre optic procedures are performed in rooms with own equipment. Please note: Modifier 0075 is not applicable to any of the items for diagnostic procedures in the otorhinolaryngology sections of the tariff		21.00	R120.54	21.00	R120.54		
0077	Physical treatment: When two separate areas are treated simultaneously for totally different conditions, such treatment shall be regarded as two treatments for which separate fees may be charged. (Only applicable if services are provided by a specialist in physical medicine)							
0078	When a testis biopsy is done combined with vasogram or seminal vesiculogram or epididymogram, add 50% of the units for the appropriate procedure							
0079	When a first consultation/visit proceeds into, or is immediately followed by a medical psychotherapeutic procedure, fees for the procedure are calculated according to the appropriate individual psychotherapy code (items 2957, 2974 or 2975)							
0080	Multiple examinations: Full Fee							
0081	Repeat examinations: No reduction							
0082	"+" Means that this item is complementary to a preceding item and is therefore not subject to reduction							

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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						
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 and must be based on the prices published by them in 2003)						
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						
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						
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)						
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)						
0092	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) (refer to Rule YY)						
0093	The fees for radiation oncology shall apply only where a specialist in radiation oncology uses his own equipment						
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. A material code list with descriptions and guideline costs for these materials, maintained and updated on a regular basis, will be supplied by the Society of Clinical and Radiation Oncology. 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						
0096	Radio-isotope therapy patients who fail to keep their appointments: Fee will include cost of isotope						
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						
0099	Stat basis tests: For tests performed on a stat basis, an additional premium of 50% of the fee for the particular pathology service shall apply, with the following provisos. o Specimens must be collected on a stat basis where applicable. o Test must be performed on a stat basis. o Documentation (or a copy thereof) relating to the request of the referring practitioner must be retained. o This modifier will only apply during normal working hours and will never be used in combination with item 4547: After-hours service						
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						
0160	Aspiration of biopsy procedure performed under direct ultrasound control by an ultrasound aspiration biopsy transducer (Static Realtime): Fee for part examined plus 30% of the units						
0165	Use of contrast during ultrasound study: add 6.00 ultrasound units		6.00	R32.94	6.00	R32.94	
0170	Multiple areas treated in the same treatment session: Unless otherwise identified in the tariff, where treating multiple treatment volumes/areas which add significant time and/or complexity, and when each treatment volume/area is clearly identified and defined, the following values shall prevail: 100% (full value) for the first volume/area, 66,67% for the second volume/area and 33,33% for the third volumes/areas. This modifier is applicable to sections 20.1 and 20.4						
0172	Specialised radiation technique: The following cases are regarded as being unusually complex in nature and therefore the recommended charge is the fee for the applicable code in use + 100%. This modifier is applicable to section 20.6 only. The codes affected are: 5123-5125, 5902-5904, 5132-5134 and 5907-5909. The specialised teletherapy procedures include Mantle field radiation, Inverted Y radiation, Total Nodal Irradiation (TNI), Craniospinal radiation, whole body or fractionated hemi body radiation, IMRT, MLC radiation and special beam considerations (multiple electron areas/volumes, proton and neutron therapy)						
5104	Ultrasound in pregnancy, multiple gestation, after twenty weeks: plus 50%						
5441	Add one (1,00) anaesthetic unit, except where the procedure refers to the bones named in Modifiers 5442 to 5448					1.00	R30.24
5442	Shoulder, scapula, clavicle, humerus, elbow joint, upper 1/3 tibia, knee joint, patella, mandible and temporo-mandibular joint: Add two (2,00) anaesthetic units					2.00	R60.48
5443	Maxillary and orbital bones: Add three (3,00) anaesthetic units					3.00	R90.72
5444	Shaft of femur: Add four (4,00) anaesthetic units					4.00	R120.96
5445	Spine (except coccyx), pelvis, hip, neck of femur: Add five (5,00) anaesthetic units					5.00	R151.20

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5448	Sternum and/or ribs and musculo-skeletal procedures which involve an intra-thoracic approach: Add eight (8,00) anaesthetic units						8.00	R241.92
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							
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							
6102	All post-contrast studies (except bone tumour), including perfusion studies, to be charges at 50% of the fee							
6103	Post-contrast study: Bone tumour: 100% of the fee							
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							
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							
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							
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							
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"							
6109	Very limited studies to be charged at 33,33% of the full fee e.g. MR urography for renal colic, diffusion studies of the brain additional to routine brain							
6110	MRI spectroscopy: 50% of fee							
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)							
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)							
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)							
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							
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							
I.	Consultative Services							
	Practice Types							

I.a General Practitioner visits

Code	Description
0181	General practitioner: New and follow-up patient: Visit/consultation for a patient with problem focused history, examination and management during which the doctor spends up to 10 minutes with the patient or the family
0182	General practitioner: New and follow-up patient: Visit/consultation for a patient with expanded problem focused history, examination and management during which the doctor spends 10-20 minutes with the patient or the family
0183	General practitioner: New and follow-up patient: Visit/consultation for a patient with comprehensive history, examination and management during which the doctor spends 20-30 minutes with the patient or the family
0184	General practitioner: New and follow-up patient: Visit/consultation for a patient with comprehensive history, examination and management during which the doctor spends 30-45 minutes with the patient or the family
0185	General practitioner: New and follow-up patient: Visit/consultation for a patient with comprehensive history, examination and management during which the doctor spends 45-60 minutes with the patient or the family

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PracticeType	0181	0182	0183	0184	0185
14	117.20	117.20	117.20	117.20	117.20

I.b Specialists tiered consultation structure

Code	Description
0141	Specialist: New and established patients: Consultation/visit of new or established patient with problem focused history, clinical examination and straightforward decision making for minor problem. Typically occupies the doctor personally with the patient for between 10 and 20 minutes.
0142	Specialist: New and established patients: Consultation/visit of new or established patient with detailed history, clinical examination and straightforward decision making and counselling. Typically occupies the doctor personally with the patient for between 20 and 35 minutes
0143	Specialist: New and established patients: Consultation/visit of new or established patient with detailed history, complete clinical examination and moderately complex decision making and counselling. Typically occupies the doctor personally with the patient or between 30 and 40 minutes
0144	Specialist: New and established patients: Consultation/visit of new or established patient with comprehensive history and clinical examination for complex problem requiring complex decision making and counselling. Typically occupies a doctor personally with the patient for between 45 and 60 minutes

PracticeType	0141	0142	0143	0144
10	126.90	126.90	126.90	126.90
12	119.00	119.00	119.00	119.00
16	142.70	142.70	142.70	142.70
17	214.10	214.10	214.10	214.10
18	214.10	214.10	214.10	214.10
19	214.10	214.10	214.10	214.10
20	214.10	214.10	214.10	214.10
21	214.10	214.10	214.10	214.10
22	214.10	214.10	214.10	214.10
23	214.10	214.10	214.10	214.10
24	214.10	214.10	214.10	214.10
25	214.10	214.10	214.10	214.10
26	126.90	126.90	126.90	126.90
28	126.90	126.90	126.90	126.90
30	119.00	119.00	119.00	119.00
31	214.10	214.10	214.10	214.10
32	216.30	216.30	216.30	216.30
33	216.30	216.30	216.30	216.30
34	214.10	214.10	214.10	214.10
36	119.00	119.00	119.00	119.00
38	111.00	111.00	111.00	111.00
40	126.90	126.90	126.90	126.90
42	126.90	126.90	126.90	126.90

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44	206.20	206.20	206.20	206.20
46	126.90	126.90	126.90	126.90
52	111.00	111.00	111.00	111.00
53	111.00	111.00	111.00	111.00

I.c General practitioner and specialist services

Code	Description
0109	Hospital follow-up visit to patient in ward or nursing facility
0129	Prolonged first/follow-up consultation/visit per 15 minutes (to be added to item 0144 [specialist] or item 0185 [general practitioner] only if service extends 10 minutes or more into the next 15-minute period following on the first 60 minutes)
0145	For consultation/visit away from the doctor's home or rooms: ADD to any of items 0141-0144 (specialists) or items 0181-0185 (general practitioners) as appropriate. Please note that item 0145 is not applicable for pre-anaesthetic assessments and may not be added to any of items 0151-0153
0146	For emergency or unscheduled consultation/visit, all hours: ADD to any of items 0141-0144 (specialists); items 0151-0153 or items 0181-0185 (general practitioners) as appropriate
0147	For emergency or unscheduled consultation/visit away from the doctor's home or rooms, all hours: ADD to any of items 0141-0144 (specialists); items 0151-0153 or items 0181-0185 (general practitioners) as appropriate

PracticeType	0109	0129	0145	0146	0147
14	79.30	119.00	0.00	63.40	111.00
999	79.30	119.00	0.00	63.40	111.00

I.e Pre-anaesthetic assessment

Code	Description
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
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
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

PracticeType	0151	0152	0153
10	126.90	126.90	126.90
14	126.90	126.90	126.90

I.f Prenatal visits and new born attendance

Code	Description
2601	First pre-natal visit
2602	Repeat pre-natal visit
0107	New born attendance: Exclusive attendance to baby at Caesarean section, normal delivery or visit in the ward

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0113	New born attendance: Emergency attendance to newborn at all hours
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PracticeType	0107	0113	2601	2602
14	264.30	360.40	117.20	95.20
999	264.30	360.40	142.70	95.20

I.g Consultative services: Miscellaneous

Code	Description
0130	Telephone consultation (all hours)
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)
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
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

PracticeType	0130	0132	0133	0199
10	95.20			
12	95.20			
14	95.20	39.60	71.40	169.90
16	95.20			
17	142.70			
18	142.70			
19	142.70			
20	142.70			
21	142.70			
22	142.70			
23	142.70			
24	142.70			
25	142.70			
26	95.20			
28	95.20			
30	95.20			
31	142.70			
32	144.20			
33	144.20			
34	142.70			
36	95.20			
38	95.20			

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40	95.20			
42	95.20			
44	134.80			
46	95.20			
52	95.20			
53	95.20			
999		39.60	71.40	169.90