No. R. 771 **21 July 2008**

ROAD ACCIDENT FUND ACT, 1996 (ACT NO. 56 OF 1996), AS AMENDED

ROAD ACCIDENT FUND REGULATIONS, 2008

The Road Accident Fund hereby, under regulation 5(2) of the Road Accident Fund Regulations, 2008, made under the Road Accident Fund Act, 1996 (Act No. 56 of 1996), as amended, gives notice of the tariff set out in the Schedule hereto.

This notice shall come into operation on 1 August 2008.

SCHEDULE

AMBULANCE SERVICES

This schedule is only applicable to road accident trauma emergency care where the RAF is liable for compensation in terms of the Road Accident Fund Act (Act Nr 56 of 1996) as amended.

Emergency care means the immediate, appropriate and justifiable medical assessment, treatment and care required to prevent or limit future impairment to bodily functions and/or to preserve the person's life.

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 should be followed.
ALL PRICES ARE VAT EXCLUSIVE.

Preamble

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

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.	06.52
002	No after hours fees may be charged	06.52
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.	06.52
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.	06.52
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.	06.52
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.	06.52

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.	06.52

Code	Description	Ver	Add	Ambulance Services : Advanced Life Support		Ambulance Services : Intermediate Life Support		Ambulance Services : Basic Life Support		Ambulance Services - Other	
				RVU	Fee	RVU	Fee	RVU	Fee	RVU	Fee
	· 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.										
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.										06.52

STAATSKOERANT, 21 JULIE 2008 No. 31249 121

Code	Description	Ver	Add	Ambulance Services : Advanced Life Support		Ambulance Services : Intermediate Life Support		Ambulance Services : Basic Life Support		Ambulance Services - Other	
				RVU	Fee	RVU	Fee	RVU	Fee	RVU	Fee
	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.										
1	**BASIC LIFE SUPPORT**										
Metropolitan area											
100	Up to 45 minutes	06.52		171.276	766.10	171.276	766.10	171.276	766.10		
102	Up to 60 minutes	06.52		228.156	1020.50	228.156	1020.50	228.156	1020.50		
103	Every 15 minutes thereafter or part thereof, where specially motivated	06.52		57.084	255.40	57.084	255.40	57.084	255.40		
Long distance											
111	Per km (> 100 km) DISTANCE TRAVELLED BY PATIENT	06.52		2.843	12.70	2.843	12.70	2.843	12.70		
112	Per km (> 100 km) (BLS return - non patient carrying kilometres) to a maximum of R1986.40	06.52		1.000	4.47	1.000	4.47	1.000	4.47		
2	**INTERMEDIATE LIFE SUPPORT**										
Metropolitan area											
125	Up to 45 minutes	06.52		231.226	1034.20	231.226	1034.20	-	-		
127	Every 15 minutes thereafter or part thereof, where specially motivated	06.52		77.075	344.70	77.075	344.70	-	-		
Long distance											
129	Per km (> 100 km) DISTANCE TRAVELLED BY PATIENT	06.52		3.850	17.20	3.850	17.20	-	-		
130	Per km (> 100 km) (ILS return - non patient carrying kilometres) to a maximum of R1986.40	06.52		1.000	4.47	1.000	4.47	-	-		
3	**ADVANCED LIFE SUPPORT / INTENSIVE CARE UNIT**										
Metropolitan area											
131	Up to 60 minutes	06.52		406.641	1818.90	-	-	-	-		
133	Every 15 minutes thereafter or part thereof, where specially motivated.	06.52		101.660	454.70	-	-	-	-		
Long distance											
141	Per km (> 100 km) DISTANCE TRAVELLED BY PATIENT	06.52		5.072	22.70	-	-	-	-		
142	Per km (> 100 km) (ALS return - non patient carrying kilometres) to a maximum of R1986.40	06.52		1.000	4.47	-	-	-	-		
4	**ADDITIONAL VEHICLE OR STAFF FOR INTERMEDIATE LIFE SUPPORT, ADVANCED LIFE SUPPORT AND INTENSIVE CARE UNIT**										
151	Resuscitation fee, per incident	06.52		454.000	2030.60	454.000	2030.60	-	-		
153	Doctor per hour	06.52		130.000	581.50	130.000	581.50	-	-		

Code	Description	Ver	Add	Ambulance Services : Advanced Life Support		Ambulance Services : Intermediate Life Support		Ambulance Services : Basic Life Support		Ambulance Services - Other	
				RVU	Fee	RVU	Fee	RVU	Fee	RVU	Fee
	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	06.52									
	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.										06.52
5.	**AEROMEDICAL TRANSFERS**										
	BY ARRANGEMENT WITH THE ROAD ACCIDENT FUND										08.51
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 night time operation rates apply (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. Should a response aircraft go to a scene and not render any treatment then the Road Accident Fund shall not be liable. 6. Flying time shall be calculated per minute but a minimum of 30 minutes apply to the payment. 7. If two patients are transferred simultaneously 75% of the Basic costs and flight costs shall apply but Staff and Consumables costs remain per patient. (Only if aircraft capability allows for multiple patients). 8. Rates are calculated according to time; from throttle open, to throttle closed. 9. Group A - C must fall within the Cat 138 Ops as determined by Civil Aviation. 10. Hot loads restricted to 8 minutes ground time and must be indicated separately with the indicated code (time NOT to be included in actual flying time).										08.51
	AIRCRAFT TYPE A: (typically a single engine aircraft) HB206L, HB204 / 205, HB407, AS360, EC120, MD600, AS350, A119 AIRCRAFT TYPE B & Ca (DAY OPERATIONS): (typically a twin engine aircraft) B0105, 206CT, AS355, A109 AIRCRAFT TYPE Cb (NIGHT OPERATIONS): (typically specially equipped craft for night flying) HB222, HB212 / 412, AS365, S76, HB427, MD900, BK117, EC135, BO105 AIRCRAFT TYPE D (RESCUE) H500, HB206B, AS350, AS315, FH1100, EC130, S316										08.51
Rotorwing Type A											
700	Basic call cost	08.51								163.778	7326.90
701	Flying time : Cost per minute up to 120 minutes	08.51								2.605	116.60
	Minimum cost for 30 minutes applicable. Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes.	08.51									
702	Hot load (per minute) – maximum 8 minutes	08.51								1.737	77.70
Rotorwing Type B & Ca (Day Operations) : Transport											
710	Basic call cost	08.51								287.850	12877.50
711	Flying time : Cost per minute up to 120 minutes	08.51								4.496	201.10

STAATSKOERANT, 21 JULIE 2008 No. 31249 123

Code	Description	Ver	Add	Ambulance Services : Advanced Life Support		Ambulance Services : Intermediate Life Support		Ambulance Services : Basic Life Support		Ambulance Services - Other	
				RVU	Fee	RVU	Fee	RVU	Fee	RVU	Fee
	Minimum cost for 30 minutes applicable. Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes.	08.51									
712	Hot load (per minute) – maximum 8 minutes	08.51								4.496	201.10
Rotorwing Type Cb (Night Operations) : Transport											
720	Basic call cost	08.51								409.428	18316.50
721	Flying time : Cost per minute up to 120 minutes	08.51								4.496	201.10
	Minimum cost for 30 minutes applicable. Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes.	08.51									
722	Hot load (per minute) – maximum 8 minutes	08.51								4.496	201.10
Rotorwing Type A, B and C : Staff and consumables											
730	Staff and consumables : 1 – 30 minutes	08.51								25.777	1153.20
731	Staff and consumables : 31 – 60 minutes	08.51								51.555	2306.40
732	Staff and consumables : 61 – 90 minutes	08.51								77.332	3459.60
733	Staff and consumables : more than 90 minutes	08.51								103.106	4612.60
Rotorwing Type D : Transport											
740	Basic call cost	08.51								345.417	15452.90
741	Flying time : Cost per minute up to 120 minutes	08.51								5.361	239.80
	Minimum cost for 30 minutes applicable. Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes.	08.51									
742	Hot load (per minute) – maximum 8 minutes	08.51								5.361	239.80
Other Costs											
595	Winching, per lift	06.52								44.953	2011.10
Air Ambulance : Fixed Wing Rates											
	DEFINITIONS: 1. Group A must fall within the Cat 138 Ops as determined by Civil Aviation. 2. Please note that 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. As these would only be used during emergencies when no Group A aircraft are available, no staff or equipment fee would be advised. 3. Staff and consumables cost can only be used if the patient has been treated. 4. If two patients are transferred simultaneously 75% of the Basic costs and flight costs shall apply but Staff and Consumables costs remain per patient. (Only if aircraft capability allows for multiple patients)										08.51
Fixed wing Group A											
	(Tariff is composed of flying cost per kilometer and staff and equipment cost per minute)										08.51
Fixed wing Group A : Aircraft cost (per kilometer)											
651	Beechcraft Duke	06.52								0.657	29.40
653	Lear 24F	06.52								1.033	46.20
655	Lear 35	06.52								1.033	46.20
657	Falcon 10	06.52								1.194	53.40
659	King Air 200	06.52								0.946	42.30
661	Mitsubishi MU2	06.52								1.033	46.20
663	Cessna 402	06.52								0.573	25.60
665	Beechcraft Baron	06.52								0.496	22.20

Code	Description	Ver	Add	Ambulance Services : Advanced Life Support		Ambulance Services : Intermediate Life Support		Ambulance Services : Basic Life Support		Ambulance Services - Other	
				RVU	Fee	RVU	Fee	RVU	Fee	RVU	Fee
667	Citation II	06.52								0.785	35.10
669	Pilatus PC12	06.52								0.785	35.10
Fixed wing Group A : Staff cost											
750	Doctor – cost per minute	08.51								0.827	37.00
	Minimum cost for 30 minutes applicable.	08.51									
751	ICU Sister – cost per minute	08.51								0.302	13.50
	Minimum cost for 30 minutes applicable.	08.51									
752	Paramedic – cost per minute	08.51								0.302	13.50
	Minimum cost for 30 minutes applicable.	08.51									
Fixed wing Group A : Equipment cost											
760	Per patient – cost per minute	08.51								0.369	16.50
Fixed Wing 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 time period for transportation and stabilisation of the patient.										08.51
770	Service rendered to be clearly specified with cost included. Each case will be reviewed and assessed on merit.	08.51								-	
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.										06.52

Clinical Technologists 2008

SERVICES BY CLINICAL TECHNOLOGISTS

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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 should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

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.	06.52

MODIFIERS

0001	Fee prorated according to number of treatment days;. fee = ([number of treatment days] / 30) X (item fee)	06.52

ITEMS

Surgical Support

Code	Description	Ver	Add	Clinical Technology	
				RVU	Fee
010	Ablations	06.52		219.700	1667.30 (1462.50)
011	Preparation of extra-corporeal equipment for surgical procedures.	06.52		196.700	1492.80 (1309.50)
012	Operation of heart laser during myocardial revascularisation	06.52		219.700	1667.30 (1462.50)
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	06.52		20.300	154.10 (135.20)
014	Radiofrequency Catheter Ablations	06.52		219.700	1667.30 (1462.50)
	Not to be charged with item 012	06.52			
015	Preparation and operation of pre-operative, intra-operative or post operative physiological monitoring per patient, per admission	06.52		19.400	147.20 (129.10)
	May only submit once in theatre and once in catheterisation laboratory	06.52			
017	Standby with extra-corporeal equipment for surgery within hospital	06.52		58.800	446.20 (391.40)
	Cannot be used with 011	06.52			
019	Standby within the hospital for coronary angioplasty.	06.52		19.400	147.20 (129.10)
021	Preparation and operation of intra-aortic balloon pump in theatre, intensive care unit and catheterisation laboratory.	06.52		58.800	446.20 (391.40)
085	Each additional 30 minutes or part thereof, provided that such part comprises 50% or more of the time.	06.52		10.000	75.90 (66.60)
023	Global fee for preparation and operation and removal of cardio assist device (LVAD, RVAD, BVAD) in theatre and intensive care unit.	06.52		196.700	1492.80 (1309.50)
027	Preparation and operation of a pre- and post-operative blood salvage device.	06.52		19.400	147.20 (129.10)
029	Preparation and operation of an autotransfusion cell washing system.	06.52		77.100	585.10 (513.20)
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)	06.52		61.700	468.20 (410.70)
033	Assistance with bronchoscopy procedures, placement of arterial/venous catheters, ultrasound examinations or photography.	06.52		14.600	110.80 (97.20)
034	Lymph compression treatment.	06.52		22.500	170.80 (149.80)
116	Preparation and operation of an artificial heart (Berlin-Heart)	06.52		219.700	1667.30 (1462.50)
118	Daily monitoring of artificial heart, per hour	06.52		33.400	253.50 (222.40)
157	Standby with extra corporeal equipment (maximum 4 hours) (per event).	06.52		26.300	199.60 (175.10)

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.				06.52
035	Nebulization (per one procedure).	06.52		12.300	93.30 (81.80)
037	Measurement of Lung volumes and capacities by means of closed circuit (He) or (N2) washout or body plethysmography.	06.52		24.200	183.70 (161.10)

Code	Description	Ver	Add	Clinical Technology	
				RVU	Fee
039	Flow-volume determinations.	06.52		30.600	232.20 (203.70)
041	Flow-volume (Pre-post B-D).	06.52		50.800	385.50 (338.20)
043	Airways resistance and conductance measurements using plethysmograph or similar apparatus.	06.52		24.200	183.70 (161.10)
045	Gas distribution measurements.	06.52		24.200	183.70 (161.10)
047	Diffusion determinations.	06.52		24.200	183.70 (161.10)
050	ECMO change-out and re-establishment.	06.52		46.300	351.40 (308.20)
Cardiology					
062	Assist in preparations and operations of Rotablator Procedures	06.52		29.900	226.90 (199.00)
063	Cardiac catheterisation for the first hour.	06.52		40.300	305.80 (268.20)
065	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time	06.52		10.000	75.90 (66.60)
064	Intravascular Ultrasound (IVUS)	06.52		25.700	195.00 (171.10)
	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	06.52			
068	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time.	06.52		10.000	75.90 (66.60)
066	Cardiac Cath Right Heart Studies	06.52		56.000	425.00 (372.80)
067	Cardiac Electro physiology and related procedures for first FOUR hours.	06.52		67.900	515.30 (452.00)
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).	06.52		46.300	351.40 (308.20)
150	Acute haemodialysis	06.52		317.200	2407.20 (2111.60)
	Emergency dialysis treatment in hospital; includes dialyser, bloodlines, acetate/bicarbonate dialysate, priming set, equipment set-up, up to 5 hours treatment time, equipment rental	06.52			
151	Treatment procedures for CRRT up to 6 hours or part thereof provided that such part comprises 50% or more of the time	06.52		24.800	188.20 (165.10)
152	Treatment procedure for CRRT up to 12 hours or part thereof provided that such part comprises more than 6 hours of the time	06.52		49.700	377.20 (330.90)
154	Treatment procedure for CRRT up to 18 hours or part thereof provided that such part comprises more than 12 hours of the time	06.52		74.500	565.40 (496.00)
156	Treatment procedure for CRRT up to 24 hours or part thereof provided that such part comprises more than 18 hours of the time	06.52		99.300	753.60 (661.10)
153	Patient training in centre for dialysis, CPAP training and problem-solving, home ventilators and nebulisers, per 30 minutes (to maximum of 24 hours)	06.52		16.600	126.00 (110.50)
155	Patient training or follow-up at patient's home, for dialysis, home ventilators and nebulisers, per 30 minutes (to maximum of 24 hours).	06.52		29.100	220.80 (193.70)
Miscellaneous					
171	Travelling per km in excess of 16km (in own car).	06.52		0.675	5.12 (4.49)
173	Equipment hire (By arrangement with the Fund).	06.52		-	-
175	Medication / Material	06.52		-	-
	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.	06.52			

SERVICES BY MEDICAL PRACTITIONERS		
This schedule is only applicable to road accident trauma emergency care where the RAF is liable for compensation in terms of the Road Accident Fund Act (Act Nr 56 of 1996) as amended. Emergency care means the immediate, appropriate and justifiable medical assessment, treatment and care required to prevent or limit future impairment to bodily functions and/or to preserve the person's life. 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 should be followed. VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.		
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.	06.52
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)	06.52
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.	06.52
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	06.52
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	06.52
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	06.52
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	06.52
H.	Removal of lesions: Items involving removal of lesions include follow-up treatment for 10 days	06.52
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.	06.52
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	06.52
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	06.52
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	06.52
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 Fund for what amount the will accept responsibility in respect of such treatment, should the practitioner wish any direct payment from the Fund	06.52

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology		
				RVU	Fee	RVU	Fee	RVU	Fee	
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. The Fund benefits will not be applicable in such instances.									06.52
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)									06.52
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)									06.52
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.									06.52
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									06.52
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.									06.52
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									06.52
Y.	Except where otherwise indicated, radiologists are entitled to charge for contrast material used									06.52
Z.	No fee is subject to more than one reduction									06.52
AA.	Procedures to exclude cost of isotope									06.52
EE.	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									06.52
FF.	(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.									06.52
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									06.52
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").									06.52

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology		
				RVU	Fee	RVU	Fee	RVU	Fee	
XX.	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									06.52
YY.	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)									06.52
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									06.52
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									06.52
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)									06.52
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									06.52
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.	06.52		15.000	105.42 (92.47)	15.000	105.42 (92.47)			
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									06.52
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									06.52
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.									06.52
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)									06.52
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									06.52
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									06.52

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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								06.52
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)	06.52		7.500	85.12 (74.67)	7.500	85.12 (74.67)		
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								06.52
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								06.52
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								06.52
0047	A fracture NOT requiring reduction shall be charged on a fee per service basis								06.52
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)	06.52		27.000	189.76 (166.46)	27.000	189.76 (166.46)		
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	06.52		77.000	541.16 (474.70)	77.000	541.16 (474.70)		
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)	06.52		115.500	811.73 (712.04)	115.500	811.73 (712.04)		
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	06.52		77.000	541.16 (474.70)	77.000	541.16 (474.70)		
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	06.52		32.000	224.90 (197.28)	32.000	224.90 (197.28)		
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	06.52		77.000	541.16 (474.70)	77.000	541.16 (474.70)		
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								06.52
0058	Revision operation for total joint replacement and immediate re-substitution (infected or non-infected): per fee for total joint replacement + 100%								06.52
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								06.52
0063	Where two specialists work together on a replantation procedure, each shall be entitled to two-thirds of the fee for the procedure								06.52
0064	Where the replantation is unsuccessful, no further surgical fee is payable for amputation of the non-viable parts								06.52
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								06.52
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								06.52
0067	Microsurgery of the larynx: Add 25% to the fee of the operation performed (For other operations requiring the use of an operation microscope, the fee include the use of the microscope, except where otherwise specified elsewhere in the Tariff)								06.52
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								06.52

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology		
				RVU	Fee	RVU	Fee	RVU	Fee	
0070	Add 45,00 clinical procedure units to procedure(s) performed through a thorascope	06.52		45.000	316.26 (277.42)	45.000	316.26 (277.42)			
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									06.52
0074	Endoscopic procedures performed with own equipment: The basic procedure fee plus 33.33% (1/3) of that fee ("+" codes excluded) will apply where endoscopic procedures are performed with own equipment.									06.52
0075	Endoscopic procedures performed in own procedure rooms: The fee plus 21,00 clinical procedure units will apply where endoscopic procedures are performed in rooms with own equipment. This fee is chargeable by medical practitioners who own or rent the facility. Please note: Modifier 0075 is not applicable to any of the items for diagnostic procedures in the otorhinolaryngology sections of the tariff.	06.52		21.000	147.59 (129.46)	21.000	147.59 (129.46)			
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)									06.52
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)									06.52
0080	Multiple examinations: Full Fee									06.52
0081	Repeat examinations: No reduction									06.52
0082	"+" Means that this item is complementary to a preceding item and is therefore not subject to reduction									06.52
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									06.52
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)									06.52
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									06.52
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									06.52
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)									06.52
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)									06.52
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)									06.52
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									06.52
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									06.52
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									06.52
0165	Use of contrast during ultrasound study: add 6.00 ultrasound units	06.52		6.000	40.19 (35.25)	6.000	40.19 (35.25)			
5104	Ultrasound in pregnancy, multiple gestation, after twenty weeks: plus 30%									06.52
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									06.52
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									06.52
6102	All post-contrast studies (except bone tumour), including perfusion studies, to be charges at 50% of the fee									06.52
6103	Post-contrast study: Bone tumour: 100% of the fee									06.52
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									06.52
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									06.52

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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								06.52
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								06.52
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"								06.52
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								06.52
6110	MRI spectroscopy: 50% of fee								06.52
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)								06.52
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)								06.52
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)								06.52
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								06.52
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								06.52
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
0161	Psychiatry ('22'): 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 between 10 and 20 minutes (for hospital consultation/visit by psychiatrist - refer to items 0166-0169)	06.52		15.000	203.00 (178.10)				
0162	Psychiatry ('22'): 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 between 21 and 35 minutes (for hospital consultation/visit by psychiatrist - refer to items 0166-0169)	06.52		27.500	372.20 (326.50)				
0163	Psychiatry ('22'): 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 between 36 and 45 minutes (for hospital consultation/visit by psychiatrist - refer to items 0166-0169)	06.52		40.000	541.40 (474.90)				
0164	Psychiatry ('22'): 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 between 46 and 60 minutes (for hospital consultation/visit by psychiatrist - refer to items 0166-0169)	06.52		52.500	710.60 (623.30)				
0166	Psychiatry (22): First hospital consultation/visit 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	06.52		15.000	203.00 (178.10)				
0167	Psychiatry (22): First hospital consultation/visit with detailed history, clinical examination and straightforward decision making and counselling. Typically occupies the doctor personally with the patient for between 21 and 35 minutes	06.52		27.500	372.20 (326.50)				

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology			
				RVU	Fee	RVU	Fee	RVU	Fee		
0168	Psychiatry (22): First hospital consultation/visit with detailed history, complete clinical examination and moderately complex decision making and counselling. Typically occupies the doctor personally with the patient for between 36 and 45 minutes	06.52		40.000	541.40 (474.90)						
0169	Psychiatry (22): First hospital consultation/visit 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 46 and 60 minutes	06.52		52.500	710.60 (623.30)						
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									06.52	
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									06.52	
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									06.52	
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)									06.52	
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)									06.52	
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)									06.52	
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)									06.52	
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									06.52	
0129	Prolonged face-to-face attendance to a patient: ADD to either item 0192, item 0175, item 0164 or item 0169 as appropriate, for each 15-minute period only if service extends 10 minutes or more into the next 15-minute period following on the first 60 minutes									06.52	+
0145	For consultation/visit away from the doctor's home or rooms (non-emergency): ADD only to the consultation/visit items 0190-0192, items 0173-0175, items 0161-0164 or items 0166-0169, as appropriate. Note: Only one of items 0145, 0146 or 0147 may be charged and not combinations thereof									06.52	+
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									06.52	+
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									06.52	+
0148	For elective after-hours services on request of the patient or family (non emergency) (refer to general rule B): ADD 50% 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 0148. Usage: This item is used when, for example, a patient or the family request the doctor for a non-emergency consultation/visit outside of the normal hours period as reflected in general rule B.									06.52	+
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									06.52	

Practice Type	0190	0191	0192	0173	0174	0175	0109	0111	0129	0145	0146	0147	0148	0149
Anaesthesiology	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)								
Cardiology	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)								

Code	Description								Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
											RVU	Fee	RVU	Fee	RVU	Fee
Cardiothoracic Surgery	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)										
Dermatology	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)										
Gastroenterology	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)										
General Medical Practice	190.80 (167.40)	190.80 (167.40)	190.80 (167.40)	190.80 (167.40)	190.80 (167.40)	190.80 (167.40)	170.20 (149.30)				170.20 (149.30)	68.10 (59.70)	90.80 (79.60)	158.90 (139.40)	-	-
Medical Oncology	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)										
Medicine (Specialist Physician)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)										
Neurology	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)										
Neurosurgery	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)										
Nuclear Medicine	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)										
Obstetrics and Gynaecology	204.30 (179.20)	204.30 (179.20)	204.30 (179.20)	204.30 (179.20)	204.30 (179.20)	204.30 (179.20)										
Opthalmology	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)										
Orthopaedics	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)										
Otorhinolaryngology	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)										
Paediatric Cardiology	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)		255.40 (224.00)								
Paediatrics	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)		255.40 (224.00)								
Pathology (Anatomical)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)										
Pathology (Clinical)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)										
Physical Medicine	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)										
Plastic and Reconstructive Surgery	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)										
Psychiatry							203.00 (178.10)				203.00 (178.10)	81.20 (71.20)	108.30 (95.00)	189.50 (166.20)	-	-
Pulmonology	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)										
Radiation Oncology	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)										

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
Radiology	192.90 (169.20) 192.90 (169.20) 192.90 (169.20) 192.90 (169.20) 192.90 (169.20) 192.90 (169.20)								
Rheumatology	295.10 (258.90) 295.10 (258.90) 295.10 (258.90) 295.10 (258.90) 295.10 (258.90) 295.10 (258.90)								
Specialists	170.20 (149.30)			170.20 (149.30)	68.10 (59.70)	90.80 (79.60)	158.90 (139.40)	-	-
Surgery	192.90 (169.20) 192.90 (169.20) 192.90 (169.20) 192.90 (169.20) 192.90 (169.20) 192.90 (169.20)								
Urology	192.90 (169.20) 192.90 (169.20) 192.90 (169.20) 192.90 (169.20) 192.90 (169.20) 192.90 (169.20)								
I.e	**Pre-anaesthetic assessment**								
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	06.52				16.000	181.60 (159.30)	16.000	181.60 (159.30)
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	06.52				16.000	181.60 (159.30)	16.000	181.60 (159.30)
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	06.52				16.000	181.60 (159.30)	16.000	181.60 (159.30)
I.f	**Prenatal visits and new born attendance**								
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)	06.52		45.000	510.70 (448.00)	45.000	510.70 (448.00)		
I.g	**Consultative services: Miscellaneous**								
0130	Telephone consultation (all hours)								06.52
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)								06.52
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								06.52

Practice Type	0130	0132	0133
Anaesthesiology	136.20 (119.50)		
Cardiology	204.30 (179.20)		
Cardiothoracic Surgery	192.90 (169.20)		
Dermatology	136.20 (119.50)		
Gastroenterology	204.30 (179.20)		
General Medical Practice	136.20 (119.50)	56.70 (49.70)	102.10 (89.60)
Medical Oncology	204.30 (179.20)		
Medicine (Specialist Physician)	204.30 (179.20)		
Neurology	204.30 (179.20)		
Neurosurgery	204.30 (179.20)		
Nuclear Medicine	204.30 (179.20)		
Obstetrics and Gynaecology	136.20 (119.50)		
Opthalmology	136.20 (119.50)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
Orthopaedics	136.20 (119.50)								
Otorhinolaryngology	136.20 (119.50)								
Paediatric Cardiology	204.30 (179.20)								
Paediatrics	204.30 (179.20)								
Pathology (Anatomical)	136.20 (119.50)								
Pathology (Clinical)	136.20 (119.50)								
Physical Medicine	204.30 (179.20)								
Plastic and Reconstructive Surgery	136.20 (119.50)								
Psychiatry	162.40 (142.50)			67.70 (59.40)				135.40 (118.80)	
Pulmonology	204.30 (179.20)								
Radiation Oncology	136.20 (119.50)								
Radiology	136.20 (119.50)								
Rheumatology	204.30 (179.20)								
Specialists				56.70 (49.70)				102.10 (89.60)	
Surgery	136.20 (119.50)								
Urology	136.20 (119.50)								
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.	06.52							
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.	06.52							
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.	06.52							
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.	06.52							

Code	Description	Ver.	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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	06.52		10.000	70.30 (61.70)	10.000	70.30 (61.70)		
II.d	**Own equipment used in treatment**								
5930	Surgical laser apparatus: Hire fee for own equipment	06.52		109.000	766.10 (672.00)	109.000	766.10 (672.00)		
5932	Candella laser apparatus: Hire fee for own equipment (Rates by arrangement with the scheme concerned)	06.52							
III.	**PROCEDURES**								
6999	Unlisted procedure/service: A procedure/service may be provided that is not listed in this edition of the coding structure. Refer to General Rule C for the criteria to use item 6999	06.52							
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)								06.52
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								06.52
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								06.52
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								06.52
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)	06.52		7.500	85.12 (74.67)	7.500	85.12 (74.67)		
1	**General**								
1.1	**Injections, Infusions and Inhalation Sedation Treatment**								
0203	Inhalation sedation: Use of analgesic nitrous oxide for alcohol and other withdrawal states: First quarter-hour or part thereof	06.52		6.000	42.20 (37.00)	6.000	42.20 (37.00)		
0204	Inhalation sedation: Per additional quarter-hour or part thereof	06.52		3.000	21.10 (18.50)	3.000	21.10 (18.50)		
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	06.52		12.000	84.30 (73.90)	12.000	84.30 (73.90)		
0206	Intravenous treatment: Intravenous infusions (push-in) (patients over three years): Insertion of cannula - chargeable once per 24 hours	06.52		6.000	42.20 (37.00)	6.000	42.20 (37.00)		
0207	Intravenous treatment: Intravenous infusions (cut-down) (patients over three years): Cut-down and insertion of cannula - chargeable once per 24 hours	06.52		8.000	56.20 (49.30)	8.000	56.20 (49.30)		
0208	Venesection: Therapeutic venesection (Not to be used when blood is drawn for the purpose of laboratory investigations)	06.52		6.000	42.20 (37.00)	6.000	42.20 (37.00)		
0209	Umbilical artery cannulation at birth	06.52		18.000	126.50 (111.00)	18.000	126.50 (111.00)		
0210	Collection of blood specimen(s) by medical practitioner for pathology examination, per venesection (not to be used by pathologists)	06.52		3.250	22.80 (20.00)	3.250	22.80 (20.00)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0211	Exchange transfusion: First and subsequent (including after-care)	06.52		80.000	562.20 (493.20)	80.000	562.20 (493.20)		
	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)	06.52							
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.								06.52
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								06.52
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.								06.52
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.								06.52
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.								06.52
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								06.52
0028	Indicator for use of low flow anaesthetic technique less than 1litre/minute: Fresh gas flow of less than 1 litre/minute								06.52
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								06.52
0030	Indicator for use of low flow anaesthetic technique 1-2 litre/minute: Fresh gas flow of 1 to 2 litre/minute								06.52
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								06.52
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								06.52
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.								06.52
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								06.52
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).								06.52

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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.								06.52
0037	Body hypothermia: Utilisation of total body hypothermia: Add 3,00 anaesthetic units	06.52						3.000	132.33 (116.08)
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								06.52
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								06.52
0040	Phaeochromocytoma: The basic anaesthetic units for procedures performed for phaeochromocytoma shall be 15,00 anaesthetic units								06.52
0041	Hyperbaric pressurisation: Utilisation of hyperbaric pressurisation: Add 3,00 anaesthetic units	06.52						3.000	132.33 (116.08)
0042	Extracorporeal circulation: Utilisation of extracorporeal circulation: Add 3,00 anaesthetic units	06.52						3.000	132.33 (116.08)
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	06.52						3.000	132.33 (116.08)
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	06.52						3.000	132.33 (116.08)
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.								06.52
	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)								06.52
5441	Add one (1,00) anaesthetic unit, except where the procedure refers to the bones named in Modifiers 5442 to 5448	06.52						1.000	44.11 (38.69)
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	06.52						2.000	88.22 (77.39)
5443	Maxillary and orbital bones: Add three (3,00) anaesthetic units	06.52						3.000	132.33 (116.08)
5444	Shaft of femur: Add four (4,00) anaesthetic units	06.52						4.000	176.44 (154.77)
5445	Spine (except coccyx), pelvis, hip, neck of femur: Add five (5,00) anaesthetic units	06.52						5.000	220.55 (193.46)
5448	Sternum and/or ribs and musculo-skeletal procedures which involve an intra-thoracic approach: Add eight (8,00) anaesthetic units	06.52						8.000	352.88 (309.54)
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)								06.52

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2	**Integumentary System**								
2.2	**Skin (general)**								
0222	Intralesional injection into areas of pathology e.g. Keloid: Single	06.52		4.000	28.10 (24.60)	4.000	28.10 (24.60)		
0223	Intralesional injection into areas of pathology e.g. Keloids: Multiple	06.52		8.000	56.20 (49.30)	8.000	56.20 (49.30)		
0233	Biopsy without suturing: First lesion	06.52		6.000	42.20 (37.00)	6.000	42.20 (37.00)	3.000	132.30 (116.10)
0234	Biopsy without suturing: Subsequent lesions (each)	06.52		3.000	21.10 (18.50)	3.000	21.10 (18.50)	3.000	132.30 (116.10)
0235	Biopsy without suturing: Maximum for multiple additional lesions	06.52		18.000	126.50 (111.00)	18.000	126.50 (111.00)	3.000	132.30 (116.10)
0237	Deep skin biopsy by surgical incision with local anaesthetic and suturing	06.52		12.000	84.30 (73.90)	12.000	84.30 (73.90)	3.000	132.30 (116.10)
0244	Repair of nail bed	06.52		30.000	210.80 (184.90)	30.000	210.80 (184.90)	3.000	132.30 (116.10)
0255	Drainage of subcutaneous abscess onychia, paronychia, pulp space or avulsion of nail	06.52		20.000	140.60 (123.30)	20.000	140.60 (123.30)	3.000	132.30 (116.10)
0257	Drainage of major hand or foot infection: Drainage of major abscess with necrosis of tissue, involving deep fascia or requiring debridement; complete excision of pilonidal cyst or sinus	06.52		87.000	611.40 (536.30)	87.000	611.40 (536.30)	3.000	132.30 (116.10)
0259	Removal of foreign body superficial to deep fascia (except hands)	06.52		20.000	140.60 (123.30)	20.000	140.60 (123.30)	3.000	132.30 (116.10)
0261	Removal of foreign body deep to deep fascia (except hands)	06.52		31.000	217.90 (191.10)	31.000	217.90 (191.10)	3.000	132.30 (116.10)
2.3	**Major plastic repair**								
0289	Large skin grafts, composite skin grafts, large full thickness free skin grafts	06.52		234.000	1644.60 (1442.60)	187.200	1315.60 (1154.00)	4.000	176.40 (154.70)
0290	Reconstructive procedures (including all stages) and skin graft by myo-cutaneous or fascio-cutaneous flap	06.52		410.000	2881.50 (2527.60)	328.000	2305.20 (2022.10)	4.000	176.40 (154.70)
0291	Reconstructive procedures (including all stages) grafting by micro-vascular re-anastomosis	06.52		800.000	5622.40 (4931.90)	640.000	4497.90 (3945.50)	4.000	176.40 (154.70)
0292	Distant flaps: First stage	06.52		206.000	1447.80 (1270.00)	164.800	1158.20 (1016.00)	4.000	176.40 (154.70)
0293	Contour grafts (excluding cost of material)	06.52		206.000	1447.80 (1270.00)	164.800	1158.20 (1016.00)	4.000	176.40 (154.70)
0294	Vascularised bone graft with or without soft tissue with one or more sets of micro-vascular anastomoses	06.52		1200.000	8433.60 (7397.90)	960.000	6746.90 (5918.30)	6.000	264.70 (232.20)
0295	Local skin flaps (large, complicated)	06.52		206.000	1447.80 (1270.00)	164.800	1158.20 (1016.00)	4.000	176.40 (154.70)
0296	Other procedures of major technical nature	06.52		206.000	1447.80 (1270.00)	164.800	1158.20 (1016.00)	4.000	176.40 (154.70)
0297	Subsequent major procedures for repair of same lesion	06.52		104.000	730.90 (641.10)	104.000	730.90 (641.10)	4.000	176.40 (154.70)
0298	Lower abdominal dermo-lipectomy	06.52		170.000	1194.80 (1048.10)	136.000	955.80 (838.40)	5.000	220.60 (193.50)

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0299	Major abdominal lipectomy with repositioning of umbilicus	06.52		275.000	1932.70 (1695.40)	220.000	1546.20 (1356.30)	5.000	220.60 (193.50)
2.4	**Lacerations, scars, tumours, cysts and other skin lesions**								
0300	Stitching of soft-tissue injuries: Stitching of wound (with or without local anaesthesia): Including normal after-care)	06.52		14.000	98.40 (86.30)	14.000	98.40 (86.30)	3.000	132.30 (116.10)
0301	Stitching of soft-tissue injuries: Additional wounds stitched at same session (each)	06.52		7.000	49.20 (43.20)	7.000	49.20 (43.20)	3.000	132.30 (116.10)
0302	Stitching of soft-tissue injuries: Deep laceration involving limited muscle damage	06.52		64.000	449.80 (394.60)	64.000	449.80 (394.60)	4.000	176.40 (154.70)
0303	Stitching of soft-tissue injuries: Deep laceration involving extensive muscle damage	06.52		128.000	899.60 (789.10)	120.000	843.40 (739.80)	4.000	176.40 (154.70)
0304	Major debridement of wound, sloughectomy or secondary suture	06.52		50.000	351.40 (308.20)	50.000	351.40 (308.20)	3.000	132.30 (116.10)
0305	Needle biopsy - soft tissue	06.52		25.000	175.70 (154.10)	25.000	175.70 (154.10)	3.000	132.30 (116.10)
0307	Excision and repair by direct suture; excision nail fold or other minor procedures of similar magnitude	06.52		27.000	189.80 (166.50)	27.000	189.80 (166.50)	3.000	132.30 (116.10)
0308	Each additional small procedure done at the same time	06.52		14.000	98.40 (86.30)	14.000	98.40 (86.30)	3.000	132.30 (116.10)
0310	Radical excision of nailbed	06.52		38.000	267.10 (234.30)	38.000	267.10 (234.30)	3.000	132.30 (116.10)
0314	Requiring repair by large skin graft or large local flap or other procedures of similar magnitude	06.52		104.000	730.90 (641.10)	104.000	730.90 (641.10)	4.000	176.40 (154.70)
0315	Requiring repair by small skin graft or small local flap or other procedures of similar magnitude	06.52		55.000	386.50 (339.00)	55.000	386.50 (339.00)	3.000	132.30 (116.10)
2.5	**Breasts**								
0316	Fine needle aspiration for soft tissue (all areas)	06.52		15.000	105.40 (92.50)	15.000	105.40 (92.50)		
0317	Aspiration of cyst or tumour	06.52		9.000	63.30 (55.50)	9.000	63.30 (55.50)	3.000	132.30 (116.10)
0319	Mastotomy with exploration, drainage of abscess or removal of mammary implant	06.52		42.000	295.20 (258.90)	42.000	295.20 (258.90)	3.000	132.30 (116.10)
0321	Biopsy or excision of cyst, benign tumour, aberrant breast tissue, duct papilloma	06.52		94.200	662.00 (580.70)	94.200	662.00 (580.70)	3.000	132.30 (116.10)
0323	Subareolar cone excision of ducts of wedge excision of breast	06.52		90.000	632.50 (554.80)	90.000	632.50 (554.80)	3.000	132.30 (116.10)
0324	Wedge excision of breast and axillary dissection	06.52		225.000	1581.30 (1387.10)	180.000	1265.00 (1109.60)	5.000	220.60 (193.50)
0325	Total mastectomy	06.52		155.000	1089.30 (955.50)	124.000	871.50 (764.50)	5.000	220.60 (193.50)
0327	Total mastectomy with axillary gland biopsy	06.52		185.000	1300.20 (1140.50)	148.000	1040.10 (912.40)	5.000	220.60 (193.50)
0329	Total mastectomy with axillary gland dissection	06.52		275.000	1932.70 (1695.40)	220.000	1546.20 (1356.30)	5.000	220.60 (193.50)

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0330	Nipple and areola reconstruction	06.52		95.000	667.70 (585.70)	95.000	667.70 (585.70)	4.000	176.40 (154.70)
0331	Subcutaneous mastectomy for disease of breast; including reconstruction but excluding cost of prosthesis: Unilateral	06.52		234.000	1644.60 (1442.60)	187.200	1315.60 (1154.00)	4.000	176.40 (154.70)
0333	Subcutaneous mastectomy for disease of breast; including reconstruction but excluding cost of prosthesis: Bilateral	06.52		410.000	2881.50 (2527.60)	328.000	2305.20 (2022.10)	4.000	176.40 (154.70)
0334	Removal of breast implant by means of capsulectomy: Per breast	06.52		234.000	1644.60 (1442.60)	187.200	1315.60 (1154.00)	4.000	176.40 (154.70)
0335	Implantation of internal subpectoral mammary prosthesis in post mastectomy patients	06.52		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	4.000	176.40 (154.70)
2.6	Burns								
0351	Major Burns: Resuscitation (including supervision and intravenous therapy - first 48 hours)	06.52		276.000	1939.70 (1701.50)	220.800	1551.80 (1361.20)	5.000	220.60 (193.50)
0353	Tangential excision and grafting: Small	06.52		100.000	702.80 (616.50)	100.000	702.80 (616.50)	5.000	220.60 (193.50)
0354	Tangential excision and grafting: Large	06.52		200.000	1405.60 (1233.00)	160.000	1124.50 (986.40)	5.000	220.60 (193.50)
2.7	Hands (skin)								
0355	Skin flap in acute hand injuries where a flap is taken from a site remote from the injured finger or in cases of advancement flag e.g. Cutler	06.52		147.400	1035.90 (908.70)	120.000	843.40 (739.80)	4.000	176.40 (154.70)
0357	Small skin graft in acute hand injury	06.52		45.000	316.30 (277.50)	45.000	316.30 (277.50)	3.000	132.30 (116.10)
0359	Release of extensive skin contracture and/or excision of scar tissue with major skin graft resurfacing	06.52		192.000	1349.40 (1183.70)	153.600	1079.50 (946.90)	3.000	132.30 (116.10)
0361	Z-plasty	06.52		220.100	1546.90 (1356.90)	176.080	1237.50 (1085.50)	3.000	132.30 (116.10)
0363	Local flap and skin graft	06.52		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	3.000	132.30 (116.10)
0365	Cross finger flap (all stages)	06.52		192.000	1349.40 (1183.70)	153.600	1079.50 (946.90)	3.000	132.30 (116.10)
0367	Palmar flap (all stages)	06.52		192.000	1349.40 (1183.70)	153.600	1079.50 (946.90)	3.000	132.30 (116.10)
0369	Distant flap: First stage	06.52		158.000	1110.40 (974.00)	126.400	888.30 (779.20)	3.000	132.30 (116.10)
0371	Distant flap: Subsequent stage (not subject to general modifier 0007)	06.52		77.000	541.20 (474.70)	77.000	541.20 (474.70)	3.000	132.30 (116.10)
0373	Transfer neurovascular island flap	06.52		230.500	1620.00 (1421.10)	184.400	1296.00 (1136.80)	3.000	132.30 (116.10)
0374	Syndactyly: Separation of, including skin graft for one web (with skin flap and graft)	06.52		242.400	1703.60 (1494.40)	193.920	1362.90 (1195.50)	3.000	132.30 (116.10)
0375	Dupuytren's contracture: Fasciotomy	06.52		51.000	358.40 (314.40)	51.000	358.40 (314.40)	3.000	132.30 (116.10)
0376	Dupuytren's contracture: Fasciectomy	06.52		218.000	1532.10 (1343.90)	174.400	1225.70 (1075.20)	3.000	132.30 (116.10)