Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
72415	MR of the right knee pre and post contrast	04.00				100.840	7352.40 (6449.50)
72900	Nuclear Medicine study – Bone limited/regional static	04.00		21.500	1567.60 (1375.10)		
72905	Nuclear Medicine study – Bone limited static plus flow	04.00		27.530	2007.30 (1760.80)		
72910	Nuclear Medicine study – Bone tomography regional	04.00		13.410	977.70 (857.60)		
Lower Leg							
73100	X-ray of the left lower leg	04.00				2.940	214.40 (188.10)
73105	X-ray of the right lower leg	04.00				2.940	214.40 (188.10)
73300	CT of the left lower leg	04.00				24.520	1787.80 (1568.20)
73305	CT of the right lower leg	04.00				24.520	1787.80 (1568.20)
73310	CT of the left lower leg contrasted	04.00				41.830	3049.90 (2675.40)
73315	CT of the right lower leg contrasted	04.00				41.830	3049.90 (2675.40)
73320	CT of the left lower leg pre and post contrast	04.00				49.710	3624.50 (3179.40)
73325	CT of the right lower leg pre and post contrast	04.00				49.710	3624.50 (3179.40)
73400	MR of the left lower leg	04.00				64.200	4681.00 (4106.10)
73405	MR of the right lower leg	04.00				64.200	4681.00 (4106.10)
73410	MR of the left lower leg pre and post contrast	04.00				102.040	7439.90 (6526.20)
73415	MR of the right lower leg pre and post contrast	04.00				102.040	7439.90 (6526.20)
73900	Nuclear Medicine study – bone limited/regional static	04.00		21.500	1567.60 (1375.10)		
73905	Nuclear Medicine study – bone limited static plus flow	04.00		27.530	2007.30 (1760.80)		
73910	Nuclear Medicine study – bone tomography regional	04.00		13.410	977.70 (857.60)		
Ankle and Foot							
	Code 74145 (toe) may not be combined with 74120 or 74125 (foot). Code 71450 (sesamoid bones) may be combined with 74120 or 74125 (foot) if requested. Codes 74120 and 74125 (foot) may only be combined with 74130 and 74135 (calcaneus) if specifically requested. Code 74160 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 74170 (introduction of contrast) may be combined with 74300 and 74305 (CT) or 74400 and 74405 (MR). The combination of 74160 (arthrography) and 74300 and 74305 (CT) or 74400 and 74405 (MR) are not supported except in exceptional circumstances with motivation.	04.00					
74100	X-ray of the left ankle	04.00				3.320	242.10 (212.40)
74105	X-ray of the right ankle	04.00				3.320	242.10 (212.40)
74110	X-ray of the left ankle with stress views	04.00				4.520	329.60 (289.10)
74115	X-ray of the right ankle with stress views	04.00				4.520	329.60 (289.10)
74120	X-ray of the left foot	04.00				2.800	204.20 (179.10)
74125	X-ray of the right foot	04.00				2.800	204.20 (179.10)
74130	X-ray of the left calcaneus	04.00				2.740	199.80 (175.30)
74135	X-ray of the right calcaneus	04.00				2.740	199.80 (175.30)
74140	X-ray of both feet – standing – single view	04.00				2.800	204.20 (179.10)
74145	X-ray of a toe	04.00				2.670	194.70 (170.80)
74150	X-ray of the sesamoid bones one or both sides	04.00				2.800	204.20 (179.10)
74160	X-ray arthrography ankle joint including introduction of contrast	04.00				15.910	1160.00 (1017.50)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
74170	X-ray guidance and introduction of contrast into ankle joint	04.00				7.410	540.30 (473.90)
74210	Ultrasound of the left ankle	04.00				6.500	473.90 (415.70)
74215	Ultrasound of the right ankle	04.00				6.500	473.90 (415.70)
74220	Ultrasound of the left foot	04.00				6.500	473.90 (415.70)
74225	Ultrasound of the right foot	04.00				6.500	473.90 (415.70)
74290	Ultrasound bone densitometry	04.00				2.040	148.70 (130.40)
74300	CT of the left ankle/foot	04.00				24.520	1787.80 (1568.20)
74305	CT of the right ankle/foot	04.00				24.520	1787.80 (1568.20)
74310	CT of the left ankle/foot – complete with 3D recon	04.00				37.810	2756.80 (2418.20)
74315	CT of the right ankle/foot – complete with 3D recon	04.00				37.810	2756.80 (2418.20)
74320	CT of the left ankle/foot contrasted	04.00				41.830	3049.90 (2675.40)
74325	CT of the right ankle/foot contrasted	04.00				41.830	3049.90 (2675.40)
74330	CT of the left ankle/foot pre and post contrast	04.00				49.710	3624.50 (3179.40)
74335	CT of the right ankle/foot pre and post contrast	04.00				49.710	3624.50 (3179.40)
74400	MR of the left ankle	04.00				64.100	4673.70 (4099.70)
74405	MR of the right ankle	04.00				64.100	4673.70 (4099.70)
74410	MR of the left ankle pre and post contrast	04.00				100.640	7337.90 (6436.80)
74415	MR of the right ankle pre and post contrast	04.00				100.640	7337.90 (6436.80)
74420	MR of the left foot	04.00				64.200	4681.00 (4106.10)
74425	MR of the right foot	04.00				64.200	4681.00 (4106.10)
74430	MR of the left foot pre and post contrast	04.00				102.040	7439.90 (6526.20)
74435	MR of the right foot pre and post contrast	04.00				102.040	7439.90 (6526.20)
74900	Nuclear Medicine study – Bone limited/regional static	04.00		21.500	1567.60 (1375.10)		
74905	Nuclear Medicine study – Bone limited static plus flow	04.00		27.530	2007.30 (1760.80)		
74910	Nuclear Medicine study – Bone tomography regional	04.00		13.410	977.70 (857.60)		
Soft Tissue							
79900	Nuclear Medicine study – Tumour localisation planar, static	04.00		20.740	1512.20 (1326.50)		
79905	Nuclear Medicine study – Tumour localisation planar, static, multiple studies	04.00		35.170	2564.30 (2249.40)		
79910	Nuclear Medicine study – Tumour localisation planar, static and SPECT	04.00		34.150	2489.90 (2184.10)		
79915	Nuclear Medicine study – Tumour localisation planar, static, multiple studies & SPECT	04.00		47.560	3467.70 (3041.80)		
79920	Nuclear Medicine study – Infection localisation planar, static	04.00		18.430	1343.80 (1178.80)		
79925	Nuclear Medicine study – Infection localisation planar, static, multiple studies	04.00		31.840	2321.50 (2036.40)		
79930	Nuclear Medicine study – Infection localisation planar, static and SPECT	04.00		31.840	2321.50 (2036.40)		
79935	Nuclear Medicine study – Infection localisation planar, static, multiple studies and SPECT	04.00		45.250	3299.30 (2894.10)		
79940	Nuclear Medicine study – Regional lymph node mapping dynamic	04.00		6.020	438.90 (385.00)		
79945	Nuclear Medicine study – Regional lymph node mapping, static, planar	04.00		24.100	1757.20 (1541.40)		

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
79950	Nuclear Medicine study – Regional lymph node mapping, static, planar, multiple studies	04.00		37.510	2734.90 (2399.00)		
79955	Nuclear Medicine study – Regional lymph node mapping and SPECT	04.00		13.410	977.70 (857.60)		
79960	Nuclear Medicine study – Lymph node localisation with gamma probe	04.00		13.410	977.70 (857.60)		
Intervention							
General							
	Codes 80600, 80605, 80610, 80620, 80630, 81660, 81680, 82600, 84660, 85640, 85645, 86610, 86615, 86620, 86630, (aspiration / biopsy / ablations etc) may be combined with the relevant guidance codes (fluoroscopy, ultrasound, CT, MR) as previously described. The machine codes 00510, 00520, 00530, 00540, 00550, 00560 may not be combined with these codes. If ultrasound guidance (00230) is used for a procedure which also attracts one of the machine codes (00510, 00520, 00530, 00540, 00550, 00560), it may not be billed for separately. Codes 80640, 80645, 87682, 87683 include fluoroscopy. Machine fees may not be added. All other interventional procedures are complete unique procedures describing a whole comprehensive procedure and combinations of different codes will only be supported when motivated.	05.03					
80600	Percutaneous abscess, cyst drainage, any region	04.00				9.370	683.20 (599.30)
80605	Fine needle aspiration biopsy, any region	04.00				4.220	307.70 (269.90)
80610	Cutting needle, trochar biopsy, any region	04.00				6.360	463.70 (406.80)
80620	Tumour/cyst ablation chemical	04.00				25.370	1849.80 (1622.60)
80630	Tumour ablation radio frequency, per lesion	05.03				21.210	1546.50 (1356.60)
80640	Insertion of CVP line in radiology suite	04.00				8.990	655.50 (575.00)
80645	Peripheral central venous line insertion	05.03				12.120	883.70 (775.20)
80650	Infiltration of a peripheral joint, any region	05.03				6.400	466.60 (409.30)
	May be combined with relevant guidance (fluoroscopy, ultrasound, CT and MR). May not be combined with machine codes 00510, 00520, 00530, 00540, 00550, 00560 or 86610 (facet joint or SI joint) or arthrogram codes.	05.03					
Neuro intervention							
81600	Intracranial aneurysm occlusion, direct	04.00				214.520	15641.10 (13720.30)
81605	Intracranial arteriovenous shunt occlusion	04.00				254.820	18579.40 (16297.70)
81610	Dural sinus arteriovenous shunt occlusion	04.00				264.330	19272.80 (16906.00)
81615	Extracranial arteriovenous shunt occlusion	04.00				157.280	11467.60 (10059.30)
81620	Extracranial arterial embolisation (head and neck)	04.00				163.120	11893.40 (10432.80)
81625	Caroticocavernous fistula occlusion	04.00				192.290	14020.20 (12298.40)
81630	Intracranial angioplasty for stenosis, vasospasm	04.00				126.920	9254.00 (8117.50)
81632	Intracranial stent placement (including PTA)	05.03				133.720	9749.80 (8552.50)
81635	Temporary balloon occlusion test	04.00				83.420	6082.30 (5335.40)
	Code 81635 does not include the relevant preceding diagnostic study and may be combined with codes 10500, 10510, 10530, 10540, 10550.	05.03					
81640	Permanent carotid or vertebral artery occlusion (including occlusion test)	04.00				178.180	12991.50 (11396.10)
81645	Intracranial aneurysm occlusion with balloon remodelling	04.00				216.350	15774.50 (13837.30)
81650	Intracranial aneurysm occlusion with stent assistance	04.00				230.450	16802.60 (14739.10)
81655	Intracranial thrombolysis, catheter directed	04.00				58.940	4297.40 (3769.60)
	Code 81655 may be combined with any of the other neuro interventional codes 81600 to 81650	05.03					
81660	Nerve block, head and neck, per level	05.03				7.660	558.50 (489.90)
81665	Neurolysis, head and neck, per level	05.03				20.140	1468.40 (1288.10)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
81670	Nerve block, head and neck, radio frequency, per level	05.03				19.040	1388.20 (1217.70)
81680	Nerve block, coeliac plexus or other regions, per level	05.03				9.280	676.60 (593.50)
Thorax							
82600	Chest drain insertion	04.00				8.820	643.10 (564.10)
82605	Trachial, bronchial stent insertion	04.00				30.360	2213.60 (1941.80)
Gastrointestinal							
83600	Oesophageal stent insertion	04.00				31.220	2276.30 (1996.80)
83605	GIT balloon dilation	04.00				24.360	1776.10 (1558.00)
83610	GIT stent insertion (non-oesophageal)	04.00				32.020	2334.60 (2047.90)
83615	Percutaneous gastrostomy, jejunostomy	04.00				25.360	1849.00 (1621.90)
Hepatobiliary							
84600	Percutaneous biliary drainage, external	04.00				33.980	2477.50 (2173.20)
84605	Percutaneous external/internal biliary drainage	04.00				37.210	2713.10 (2379.90)
84610	Permanent biliary stent insertion	04.00				51.220	3734.60 (3276.00)
84615	Drainage tube replacement	04.00				20.220	1474.30 (1293.20)
84620	Percutaneous bile duct stone or foreign object removal	04.00				49.980	3644.10 (3196.60)
84625	Percutaneous gall bladder drainage	04.00				29.580	2156.70 (1891.80)
84630	Percutaneous gallstone removal, including drainage	04.00				69.250	5049.20 (4429.10)
84635	Transjugular liver biopsy	04.00				24.930	1817.70 (1594.50)
84640	Transjugular intrahepatic Portosystemic shunt	04.00				119.470	8710.80 (7641.10)
84645	Transhepatic Portogram including venous sampling, pressure studies	04.00				81.890	5970.80 (5237.50)
84650	Transhepatic Portogram with embolisation of varices	04.00				100.810	7350.30 (6447.60)
84655	Percutaneous hepatic tumour ablation	04.00				15.680	1143.30 (1002.90)
84660	Percutaneous hepatic abscess, cyst drainage	04.00				13.200	962.40 (844.20)
84665	Hepatic chemoembolisation	04.00				59.440	4333.90 (3801.70)
84670	Hepatic arterial infusion catheter placement	04.00				60.300	4396.60 (3856.70)
Urogenital							
85600	Percutaneous nephrostomy, external drainage	04.00				29.970	2185.20 (1916.80)
85605	Percutaneous double J stent insertion including access	04.00				40.820	2976.30 (2610.80)
85610	Percutaneous renal stone, foreign body removal including access	04.00				66.790	4869.80 (4271.80)
85615	Percutaneous nephrostomy tract establishment	04.00				29.270	2134.10 (1872.00)
85620	Change of nephrostomy tube	04.00				15.900	1159.30 (1016.90)
85625	Percutaneous cystostomy	04.00				16.520	1204.50 (1056.60)
85630	Urethral balloon dilatation	04.00				14.240	1038.30 (910.80)
85635	Urethral stent insertion	04.00				31.220	2276.30 (1996.80)
85640	Renal cyst ablation	04.00				11.920	869.10 (762.40)
85645	Renal abscess, cyst drainage	04.00				15.160	1105.30 (969.60)

Code	Description	Var	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
85655	Fallopian tube recanalisation	04.00				45.060	3285.40 (2881.90)
Spinal							
86600	Spinal vascular malformation embolisation	04.00				275.160	20062.50 (17598.70)
86605	Vertebroplasty per level	04.00				22.300	1625.90 (1426.20)
86610	Facet joint block per level, uni- or bilateral	05.03				9.540	695.60 (610.20)
	Code 86610 may only be billed once per level, and not per left and right side per level	04.00					
86615	Spinal nerve block per level, uni- or bilateral	05.03				8.160	595.00 (521.90)
86620	Epidural block	04.00				9.420	686.80 (602.50)
86625	Chemonucleolysis, including discogram	04.00				18.320	1335.70 (1171.70)
86630	Spinal nerve ablation per level	04.00				11.600	845.80 (741.90)
Vascular							
	Code 87654 (Thrombolysis follow up) may only be used on the days following the initial procedure, 87650 (thrombolysis). If a balloon angioplasty and / or stent placement is performed at more that one defined anatomical site at the same sitting the relevant codes may be combined. However multiple balloon dilatations or stent placements at one defined site will only attract one procedure code.	04.00					
87600	Percutaneous transluminal angioplasty: aorta, IVC	04.00				56.560	4123.90 (3617.50)
87601	Percutaneous transluminal angioplasty: iliac	04.00				55.760	4065.60 (3566.30)
87602	Percutaneous transluminal angioplasty: femoropopliteal	04.00				60.160	4386.40 (3847.70)
87603	Percutaneous transluminal angioplasty: subpopliteal	04.00				73.340	5347.40 (4690.70)
87604	Percutaneous transluminal angioplasty: brachiocephalic	04.00				67.120	4893.90 (4292.90)
87605	Percutaneous transluminal angioplasty: subclavian, axillary	04.00				60.160	4386.40 (3847.70)
87606	Percutaneous transluminal angioplasty: extracranial carotid	04.00				71.620	5222.00 (4580.70)
87607	Percutaneous transluminal angioplasty: extracranial vertebral	04.00				73.300	5344.40 (4688.10)
87608	Percutaneous transluminal angioplasty: renal	04.00				87.690	6393.70 (5608.50)
87609	Percutaneous transluminal angioplasty: coeliac, mesenteric	04.00				87.690	6393.70 (5608.50)
87620	Aorta stent-graft placement	04.00				120.750	8804.10 (7722.90)
87621	Stent insertion (including PTA): aorta, IVC	04.00				73.870	5386.00 (4724.60)
87622	Stent insertion (including PTA): iliac	04.00				76.370	5568.30 (4884.50)
87623	Stent insertion (including PTA): femoropopliteal	04.00				77.970	5684.90 (4986.80)
87624	Stent insertion (including PTA): subpopliteal	04.00				84.550	6164.70 (5407.60)
87625	Stent insertion (including PTA): brachiocephalic	04.00				98.470	7179.60 (6297.90)
87626	Stent insertion (including PTA): subclavian, axillary	04.00				86.690	6320.70 (5544.50)
87627	Stent insertion (including PTA): extracranial carotid	04.00				106.990	7800.90 (6842.90)
87628	Stent insertion (including PTA): extracranial vertebral	04.00				100.550	7331.30 (6431.00)
87629	Stent insertion (including PTA): renal	04.00				98.590	7188.40 (6305.60)
87630	Stent insertion (including PTA): coeliac, mesenteric	04.00				98.590	7188.40 (6305.60)
87631	Stent-graft placement: iliac	04.00				76.370	5568.30 (4884.50)
87632	Stent-graft placement: femoropopliteal	04.00				77.970	5684.90 (4986.80)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
87633	Stent-graft placement: brachiocephalic	04.00				98.470	7179.60 (6297.90)
87634	Stent-graft placement: subclavian, axillary	04.00				82.770	6034.90 (5293.80)
87635	Stent-graft placement: extracranial carotid	04.00				120.430	8780.80 (7702.50)
87636	Stent-graft placement: extracranial vertebral	04.00				114.730	8365.20 (7337.90)
87637	Stent-graft placement: renal	04.00				98.590	7188.40 (6305.60)
87638	Stent-graft placement: coeliac, mesenteric	04.00				98.590	7188.40 (6305.60)
87650	Thrombolysis in angiography suite, per 24 hours	04.00				45.820	3340.80 (2930.50)
	Code 87650 may be combined with any of the relevant non neuro interventional angiography and interventional codes 10520, 20500, 20510, 20520, 20530, 20540,32500,32530,44500, 44503, 44505, 44507, 44510, 44515, 44517, 44520, 60500, 60510, 60520, 60530, 70500, 70505, 70510, 70515, 87600 to 87638.	05.03					
87651	Aspiration, rheolytic thrombectomy	04.00				77.670	5663.10 (4967.60)
87652	Atherectomy, per vessel	04.00				91.890	6699.90 (5877.10)
87653	Percutaneous tunnelled / subcutaneous arterial or venous central or other line insertion	05.03				28.150	2052.50 (1800.40)
87654	Thrombolysis follow-up	04.00				23.570	1718.50 (1507.50)
87655	Percutaneous sclerotherapy, vascular malformation	04.00				21.100	1538.40 (1349.50)
87660	Embolisation, mesenteric	04.00				100.430	7322.60 (6423.30)
87661	Embolisation, renal	04.00				99.360	7244.50 (6354.80)
87662	Embolisation, bronchial, intercostal	04.00				108.340	7899.30 (6929.20)
87663	Embolisation, pulmonary arteriovenous shunt	04.00				103.220	7526.00 (6601.80)
87664	Embolisation, abdominal, other vessels	04.00				101.440	7396.20 (6487.90)
87665	Embolisation, thoracic, other vessels	04.00				97.600	7116.20 (6242.30)
87666	Embolisation, upper limb	04.00				90.920	6629.20 (5815.10)
87667	Embolisation, lower limb	04.00				92.140	6718.10 (5893.10)
87668	Embolisation, pelvis, non-uterine	04.00				117.120	8539.50 (7490.80)
87669	Embolisation, uterus	04.00				113.880	8303.20 (7283.50)
87670	Embolisation, spermatic, ovaria veins	04.00				85.820	6257.30 (5488.90)
87680	Inferior vena cava filter placement	04.00				61.840	4508.90 (3955.20)
87681	Intravascular foreign body removal	04.00				85.030	6199.70 (5438.30)
87682	Revision of access port (tunnelled or implantable)	05.03				14.120	1029.50 (903.10)
87683	Removal of access port (tunnelled or implantable)	05.04				11.120	810.80 (711.20)
87690	Superior petrosal venous sampling	04.00				73.010	5323.30 (4669.60)
87691	Pancreatic stimulation test	04.00				89.790	6546.80 (5742.80)
87692	Transportal venous sampling	04.00				76.950	5610.60 (4921.60)
87693	Adrenal venous sampling	04.00				55.010	4010.90 (3518.30)
87694	Parathyroid venous sampling	04.00				86.660	6318.60 (5542.60)
87695	Renal venous sampling	04.00				55.010	4010.90 (3518.30)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
ANNEXURE A							
	Radiology tariff Contrast price effective 1 Jan 2004 PER VIAL For use in conjuction with codes: 00190 X-ray examination contrast material 00290 Ultrasound examination contrast material 00390 CT examination contrast material 00490 MR examination contrast material 00590 Angiography and interventional examination contrast material Note to Funders: The following contrast items may be grouped into various categories e.g. Ionic, non-Ionic, and several items may be appropriate for use within a category. Funders may either reimburse as per identified item or may choose to apply a reference price within a category. For detail of methodology refer to Annexure B.						04.00
ANNEXURE B							
	Radiology tariff Contrast price effective 1 Jan 2004 PER VIAL						04.00
	Contrast Index Price Range - 2004 contrast prices						04.00
ANNEXURE C							
	Recommended Isotope and Kit Prices for Nuclear Medicine for 2004 by the Association of Nuclear Medicine Physicians For use in conjuction with codes: 00990 Nuclear Medicine Isotope 00991 Nuclear Medicine Substrate <<Insert object table here>>						04.00
ANNEXURE D. PET GUIDELINES							
A.	**INDICATIONS**						
	For the purposes of this guideline, only established indications for PET-CT are included and this relates to the more common types of malignancies as seen in practice. While some of the less common forms of cancer may also yield advantages with PET-CT imaging, there is as yet insufficient published data to support the general use and these have been excluded in the list below. This situation may change as new research and information becomes available.						09.00
	1. Non-small cell lung carcinoma (NSCC) a) Primary diagnosis of lesions i. >10mm diameter lesions where conventional imaging and biopsy have been inconclusive. b) Staging especially where curative surgery is planned i. Evaluation of primary tumour (T-stage). ii. Suspected nodal disease or characterization of nodal disease iii. Suspected distal metastases of determining extent of metastases. iv. Solitary distal metastasis where metastatectomy is considered. PET-CT is used to exclude additional lesions which would preclude surgery. c) Investigation of suspected recurrence (restaging) i. Local or regional recurrence ii. Nodal or distal recurrence iii. Determine the extent of proven recurrent disease iv. Differentiate fibrotic mass from active disease d) All patients with proven carcinoma of the lung, who are considered for curative resection, should be imaged with PETCT prior to surgery. e) Current available literature confirms that PET-CT is more accurate than CT or PET alone for staging and restaging of NSCC.						09.00
	2. Hodgkin's and Non-Hodgkin's Lymphoma a) Single most accurate imaging modality for Hodgkins and Non-Hodgkins lymphoma. b) Staging i. All patients prior to commencing treatment as baseline, following diagnosis. ii. Indicated at completion of therapy to confirm complete response. c) Monitoring of response to treatment i. Numerous studies have confirmed that mid-treatment PET scans predict clinical outcome. ii. Prognostic value and role in modification of therapeutic regime. d) Investigation of residual or recurrent disease (restaging) i. Where conventional imaging is equivocal for residual disease. ii. Suspected nodal recurrence. iii. Differentiating recurrent and residual disease from post-therapeutic fibrosis and scarring.						09.00
	3. Thyroid carcinoma a) Not indicated for primary diagnosis. b) Staging i. Primary examination of choice is I-123 whole body scintigraphy. ii. Only indicated for differentiated and medullary carcinoma of the thyroid in patients with negative I-123, but with a high index of suspicion for nodal or distal metastases on cross sectional imaging or where whole body I-123 scan is equivocal. c) Investigation of residual or recurrent disease (restaging) i. Elevated thyroglobulin despite negative whole body scintigraphy for differentiated thyroid carcinoma. ii. Elevated calcitonin levels and equivocal imaging findings for medullary thyroid carcinoma. iii. Solitary distal metastasis where metastatectomy is considered. PET-CT is used to exclude additional lesions which would preclude surgery.						09.00

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
	4. Head and neck carcinoma a) Primary diagnosis i. There is little, if any, role for PET-CT in primary diagnosis of mucosal lesions. ii. Limited to identifying primary tumour in histologically proven metastatic squamous cell carcinoma in cervical nodes. b) Staging of the primary tumour prior to therapy i. Local nodes which are equivocal on CI (conventional imaging). ii. Suspected distal adenopathy iii. Suspected distal metastases iv. All patients where uni- or bilateral surgery is planned (may alter management and approach by up to 50% and is significantly more accurate than CT alone). v. Excellent sensitivity (95%) for local and distal nodal disease (specificity in local disease may be affected by physiological uptake). c) Investigation of residual or recurrent disease (restaging) i. Differentiating fibrosis and recurrence where routine imaging is equivocal and may reduce the number of equivocal findings by up to 50%. ii. Following neo-adjuvant therapy for re-staging. iii. Suspected local or distal recurrence. iv. Differentiating post-therapeutic changes from residual or recurrent tumours poses significant problems for CT and MRI. PET-CT is significantly more accurate than routine cross sectional imaging in this regard.						09.00
	5. Breast cancer a) There is no role for PET-CT in the primary diagnosis, sentinel node mapping or imaging of locally contained node negative tumours. b) No role for carcinoma-in-situ. c) PET-CT imaging is limited to patients with infiltrating ductal carcinoma. d) Staging i. Only indicated if there is a significant chance of distal disease as determined by axillary dissection or where conventional imaging is equivocal. ii. Can result in up to 57% change of stage and management compared to other CI (conventional imaging). iii. High accuracy (86% vs. 77% for CT alone) for nodal and distal metastases in patient with infiltrating ductal carcinoma. e) Investigation of recurrent disease (restaging) i. Suspected local or regional recurrence. ii. Suspected nodal or distal metastatic recurrence. iii. Differentiate post therapeutic fibrosis from recurrent or residual tumour. iv. Significantly more accurate for nodal and distal recurrence than conventional imaging.						09.00
	6. Colorectal cancer a) No role in the diagnosis of the primary tumour. b) Accurate for staging (89%) and restaging (88%) c) Staging i. Suspected distal nodal metastases where conventional imaging is equivocal, particularly distal nodes. ii. Suspected distal metastases. iii. Evaluation of suspected single metastases considered for curative surgical resection to exclude concomitant disease. iv. May result in changes in treatment in up to 27% of patients. d) Investigation of residual or recurrent disease (restaging) i. Suspected local pelvic or distal recurrence. ii. Differentiate local and distal post therapeutic changes from residual and recurrent disease. iii. Evaluate and restage following neo-adjuvant therapy. iv. Evaluate patients with rising tumour markers and normal or equivocal conventional imaging.						09.00
	7. Stomach carcinoma - GIST a) In GIST tumours FDG tracer uptake is established. i. Indicated to determine response to treatment as determined by tumour activity on PET-CT measuring tracer uptake (SUV). ii. Paradigm shift in assessing tumour responses to treatment. iii. Response to Imatinib (Gleevec) can be predicted with 18FFDG as early as 24h after commencing treatment and long before any change in tumour size is demonstrated on conventional imaging. iv. Baseline study before commencing treatment is essential to determine degree of tracer uptake for post-treatment comparison. b) Variable uptake of tracer in other stomach tumours, which is difficult to explain and to predict. Routine imaging is not supported in other types of stomach tumours, at this stage.						09.00
	8. Testicular Carcinoma a) Complex histology and variable uptake of different histological sub-groups. b) Limited to seminoma and teratoma in the following cases: i. Evaluate residual mass to differentiate residual/recurrent tumour from fibrosis. ii. Suspected recurrence but normal or equivocal conventional imaging findings.						09.00
	9. Oesophageal carcinoma a) Not indicated for primary diagnosis. b) Staging for nodal and distal metastases (90% accurate) i. Indicated for N-staging, particularly where there is suspected distal nodal disease or where conventional imaging is equivocal. ii. Indicated for M- staging where distal metastases are suspected. iii. Strongly indicated for patient undergoing curative surgery to exclude distal disease. c) Investigation of residual or recurrent disease (restaging) i. Restaging for patients who have undergone neo-adjuvant chemotherapy. ii. Suspected local or distal recurrent disease. iii. Differentiate post therapeutic fibrosis from recurrent or residual disease.						09.00

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
	10.Melanoma a) No role in primary diagnosis which is primarily a surgical/histological diagnosis. b) Staging is determined by depth of penetration of the primary tumour and presence of sentinel node at surgery. i. Indicated for Stage 3 and 4 disease where there is a high incidence of distal nodal and metastatic disease. ii. Solitary distal metastasis on conventional imaging where metastatectomy is considered. PET-CT is used to exclude additional lesions which would preclude surgery. iii. Overall N and M staging is significantly more accurate than conventional imaging (97% vs 80%). c) Investigation of recurrent disease (restaging) i. Modality of choice for recurrent nodal and distal metastatic disease. ii. Differentiate post therapeutic fibrosis from recurrent or residual disease. d) PET-CT may alter management in up to 34% of patients with Stage III and IV disease.						09.00
	11.Ovarian carcinoma a) Most cases present as advanced disease. b) Recurrence is frequent and the overall 5-y survival for advanced disease is only 17%. c) Diagnosis and initial staging require a laparotomy as small peritoneal deposits may be difficult to demonstrate on imaging i. PET-CT is indicated where surgical or conventional imaging findings are equivocal for primary staging. ii. PET-CT is accurate for demonstrating nodal and distal disease. iii. Sensitivity is limited by size of peritoneal deposits. It is more accurate for macroscopic disease. d) Investigation of recurrent disease (restaging) i. Superior to CT and MRI for recurrence (92% sens. and 75% spec.). ii. Alternative to a second look laparotomy (presents significant cost saving potential). iii. Definite role for patients with rising tumour marker where conventional imaging is negative for recurrence.						09.00
	12.Carcinoma of unknown primary a) By definition, unknown primary tumors are those that remain undetected after all diagnostic resources have been used. b) PET-CT may detect up to 57% primary tumours when conventional cross sectional imaging has been negative. c) PET-CT is indicated where conventional imaging has failed to identify a primary malignancy.						09.00
B.	**LIMITED VALUE AND RELATIVE CONTRAINDICATIONS**						
	These conditions are those where there is variable or poor uptake of the tracer FDG or where imaging is routinely performed with tracers other than FDG which are not locally available. This may result in false negative findings using FDG and the routine use of PET-CT should be discouraged.						09.00
	1. Urological Malignancy a) No role in diagnosis and staging of renal cell carcinoma b) Prostate limited to suspected recurrence in histologically proven high grade tumours. Prostate is ideally imaged with Choline as tracer. c) No role for diagnosis and staging of bladder carcinoma 2. Broncho-alveolar cell carcinoma 3. Small cell carcinoma of the lung 4. Hepatocellular carcinoma 5. Sarcomas 6. Neuro-endocrine tumours 7. Anaplastic thyroid carcinoma which is Grade 4 by definition, at diagnosis. 8. Suspected brain tumours where MRI is more sensitive and specific. 9. Tumours with large mucinous components. 10.Lobular carcinoma of the breast						09.00
	In addition to these tumours, imaging should be used with caution in patients who are diabetic or who have recently used high doses of cortico-steroids.						09.00

REGISTERED NURSES IN PRIVATE PRACTICE AND NURSING AGENCIES

Registered Nurses In Private Practice and Nursing Agencies 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY REGISTERED NURSES IN PRIVATE PRACTICE AND NURSING AGENCIES, EFFECTIVE FROM 1 JANUARY 2009

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

A	GENERAL INFORMATION

The "RegN" column (Practice Type 48800) of this schedule is a reference price list for registered nurses and midwives only (not enrolled nurses) in private practice, and may only be charged by the registered nurse performing the procedure, and whose practice number is reflected on the account.

The "NAgen" column (Practice Type 48000) of this schedule is a reference price list for registered accredited nursing agencies and accredited home health care organizations only (not nurses in private practice), i.e. if employed at a nursing agency or home health care organization the private nurse practitioner may not submit claims on his / her practice number.

A registered nurse or midwife is a nurse or midwife registered with the South African Nursing Council in terms of the Nursing Act 50 of 1978 (as amended).

1. Agency refers to:

a) An accredited business registered / licensed with the S A Nursing Council carrying out the business of providing Registered and supervised Enrolled Nursing services, as well as surgicals and equipment.

b) The agency should also be registered with a representative professional governing body.

2. Home health care organisations refers to:

a) An accredited business that provides registered and supervised Enrolled Nursing services, as well as surgicals and equipment for home care.

b) The accredited home care organisation should also be registered with a representative professional governing body.

All accounts must be presented with the following information clearly stated:
i. Name of nurse practitioner, agency or home health care organization (whichever is applicable);
ii. Pre-authorisation code, when applicable
iii. Qualifications of the nurse practitioner
iv. BHF practice number
v. Section 22A permit number (if applicable)
vi. Postal address and telephone number
vii. Dates on which services were provided
viii. The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.
ix. Surname and initials of the member
x. First name of the patient
xi. Name of the scheme
xii. Membership number of the member
xiii. Where the account is a photocopy of the original, certification by way or rubber-stamp and signature of the nurse, or in the case of "80" practice numbers, the appropriate representative agent
xiv. A statement of whether the account is in accordance with the National Health Reference Price List
xv. Where the after care is taken over by the nurse practitioner, a letter of referral from the doctor with the diagnosis and treatment should be attached.

B	GENERAL RULES	
01	CONSULTATION, COUNSELING, PLANNING AND/OR ASSESSMENT: Consultation, counseling and / or assessment (codes 001 and 002 below) encompasses consultation, history taking, patient examination and assessment, observation, treatment planning, after care treatment planning, discharge planning and/or counseling. If a consultation and one or more procedures are performed in the visit, both a consultation code and the relevant procedure code(s) may be charged but the time spent on the procedure shall not be included in the consultation period for purposes of determining the consultation fee. A consultation may not be charged where the sole purpose of the visit was to perform a procedure.	04.00
02	EMERGENCY VISITS Bona-fide, justifiable emergency nursing services rendered to a patient, at any time, may attract an additional fee as specified in item 014. These specifically relate to home visits for procedures which become necessary outside those which have been pre-arranged, such as but not exclusively, blocked urinary catheters, IV therapy which tissues or wound(s) which are draining excessively and require additional dressing. These should be accompanied by a written motivation. NOTE THAT THIS FEE IS ONLY APPLICABLE TO REGISTERED NURSES IN PRIVATE PRACTICE, AND NOT TO NURSING AGENCIES.	04.00

Code	Description	Ver	Add	Nursing Agencies/Home Care Services		Registered Nurses	
				RVU	Fee	RVU	Fee
021	SUNDAYS AND PUBLIC HOLIDAYS When codes 036, 037 or 038 are charged for services rendered on a Sunday, the fee in respect of these codes shall be inflated by 50%. Modifier 0007 must be quoted after the appropriate code number(s) to indicate that this rule is applicable. When codes 036, 037 or 038 are charged for services rendered on a public holiday, the fee in respect of these codes shall be inflated by 100%. Modifier 0001 must be quoted after the appropriate code number(s) to indicate that this rule is applicable. NOTE THAT THIS FEE IS ONLY APPLICABLE TO NURSING AGENCIES AND NOT TO REGISTERED NURSES IN PRIVATE PRACTICE.						05.03
03	PROCEDURES If a composite fee or general hourly rate is charged, no additional fee for procedures may be charged. The fee in respect of more than one procedure performed at the same time shall be the fee in respect of the major procedure plus 50% of the fee of each subsidiary or additional procedure. Modifier 0002 to be quoted.						04.00
04	FEES The rate that may be charged in respect of rendering a service not listed in this benefit schedule shall be based on the rate in respect of a comparable service. Modifier 0003 to be quoted with the description of service rendered and the applicable item number used.						04.00
05	COST OF MEDICINES AND MATERIALS 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. Item 301 is to be quoted except for stomal products where item 205 is to be quoted.						04.00
051	MEDICINES Scheduled medicines may not be supplied by an institution. Intramascular/Intravenous injection and OPAT may only be administered by a registered nurse.						05.03
06	EQUIPMENT (HIRE AND SALES) Hiring equipment: 1% of the current replacement value of the equipment per day. Total charge not to exceed 50% of replacement value. Description of equipment to be supplied. To be billed in terms of item 302. Payment of this item is at the discretion of medical scheme concerned, and should be considered in instances where cost savings can be achieved. By prior arrangement with the medical scheme. For equipment that is sold to a member, the net acquisition cost of the equipment may be charged (item 303). This should be on a separate invoice attached to the account as the cost of these items are refunded to the member and not paid to the supplier.						04.00
07	MIDWIFERY The global fee is to be charged where the midwife and any assistants attend to the entire four stages of delivery. Item 399 or 403 to be quoted. No additional service fee may be levied, but pharmaceuticals may be charged under item 301. Where intravenous infusions (including blood or blood cellular products) are administered as part of the after treatment after confinement, no extra fees will be charged as this is included in the global maternity fees. Should the attending midwife prefer to ask a medical practitioner to perform intravenous infusion, then the midwife (and not the patient) is responsible for remunerating such practitioner for the infusions. When a registered midwife treats a patient in the antenatal period and after starting the confinement requests a doctor to take over the case, the registered midwife shall calculate the fee for work done up to the handover of the case. Should a midwife be required to hand over the case to a medical practitioner due to complications during a home delivery and she is required to assist, item 410 may be used. Where the confinement has not started and the midwife requests a doctor to take over the case, the fee for the visits during early labour shall be charged as item 406. This may not be combined with item 400. Antenatal/postnatal exercise or education classes are generally not covered by the schemes and payment is the responsibility of the member.						05.03
08	TRAVEL FEE Please note that generally schemes do not accept the responsibility for transport expenses, as they are deemed to be included in the fee.						04.00
09	WELL BABY CLINICS Where vaccines are issued free by the state, no charge may be levied for the product. Vaccines may only be purchased, stored and dispensed by nurses with a Section 22A (15) permit. Emergency equipment must be available in the clinic.						05.06
10	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.						04.00
MODIFIERS							
0001	Public holidays, add 100%. Nursing agencies only.						05.03
0002	Only 50% of the fee in respect of subsidiary/additional procedures may be charged.						04.00
0003	The fee that may be charged in respect of the rendering of a service not listed in this recommended benefit schedule, shall be based on the fee in respect of a fee for a comparable service. Motivation must be attached.						04.00
0007	Sundays add 50%. Nursing agencies only.						05.03

Code	Description	Ver	Add	Nursing Agencies/Home Care Services		Registered Nurses	
				RVU	Fee	RVU	Fee
ITEMS							
CONSULTATIONS (the Pathology/Diagnosis must be stated)							
Code	Description	Ver	Add	Nursing Agencies/Home Care Services		Registered Nurses	
				RVU	Fee	RVU	Fee
005	Individual consultation, counseling, planning and/or assessment. 5 - 15 minutes.	09.01		2.747	22.50 (19.70)	10.000	50.80 (44.60)
006	Individual consultation, counseling, planning and/or assessment. 16 - 30 minutes.	09.01		6.180	50.60 (44.40)	22.500	114.40 (100.40)
001	Individual consultation, counseling, planning and/or assessment. 31 - 45 minutes.	09.01		10.300	84.30 (73.90)	37.500	190.70 (167.30)
002	Individual consultation, counseling, planning and/or assessment. 46+ minutes.	06.03		14.200	116.20 (101.90)	52.500	266.90 (234.10)
014	For emergency consultation/visit, all hours - See General Rule 2.	04.00				7.700	63.00 (55.30)
SPECIMENS.							
020	This must form part of a consultation when a consultation is charged. Where a consultation was not performed and the nurse visited or attended to the patient with the sole purpose of obtaining a specimen, and dispatching to a laboratory or using own machine to test – please state specimen type and, where applicable, machine and test performed.	04.00		4.600	37.70 (33.10)	4.600	37.70 (33.10)
OBSERVATIONS. (Temperature, Pulse Respiration and B.P.)							
025	Where a consultation was not performed and the nurse attended to the patient with the sole purpose of doing an observation.	04.00		4.600	37.70 (33.10)	4.600	37.70 (33.10)
ADMINISTRATION OF MEDICATION.							
030	Where a consultation was not performed and the nurse attended to or visited the patient with the sole purpose of administering intramuscular or intravenous medication. The route of administration of medication to be stated, as well as the name of the medication. Oral, rectal, vaginal medication excluded as well as the application of topical medicine.	04.00		4.600	37.70 (33.10)	4.600	37.70 (33.10)
452	Immunisation	04.00				3.000	24.60 (21.60)
OPAT (Antibiotics, Chemotherapy, Blood Products and Dehydration)							
035	All inclusive global fee for the setting up of an IV line and administration of intravenous therapy by a registered nurse.	05.02		24.300	198.90 (174.50)	24.300	198.90 (174.50)
036	When a SRN returns to add medication to an existing IV infusion	05.02		12.200	99.90 (87.60)	12.200	99.90 (87.60)
COMPOSITE FEES							
	Note : These fees may only be charged by members of an accredited home healthcare organisation for services rendered at patient's home. (Care givers are not included in the fee). This includes all post hospitalisation/nursing care during a 24 hour period or part thereof. Motivation by a medical practitioner required. Single procedures/visits are not to be charged as a composite fee.						05.03
032	Low intensity care (Presenting problem(s) that are of low severity. The patient is stable, recovering or improving).	05.02		42.700	349.50 (306.60)		
033	Medium intensity care (Presenting problem(s) that are of moderate severity. The patient is responding inadequately to therapy or has developed a minor complication).	05.02		61.700	505.00 (443.00)		
034	High intensity care (this item presenting problem(s) that are of high complexity. The patient is unstable or has developed a significant new problem). By arrangement with scheme.	05.02		-	-		
	The above fees includes : all nursing intervention in a 24 hour period; all visits of a supervisory nature; non-recoverable items e.g. disinfectants, soaps, towellets, hibitane, aprons, fractions of strapping etc.; all travelling costs; all administrative costs; delivery/courier costs where these are necessary but excludes : any drugs and surgicals required; equipment sale or hire; auxiliary services by paraprofessionals, e.g. OT's and physiotherapists.	05.03					
	Note : Item 035 should not represent more than 4% of all claims received.						05.03
RECOMMENDED HOURLY RATES FOR REGISTERED NURSING AGENCIES							
039	Enrolled nursing assistant, per hour	05.02		3.700	30.30 (26.60)		
037	Enrolled nurse, per hour	05.03		5.100	41.70 (36.60)		
038	Registered nurse, per hour	05.03		6.460	52.90 (46.40)		

Code	Description	Ver	Add	Nursing Agencies/Home Care Services		Registered Nurses	
				RVU	Fee	RVU	Fee
	1. The fee for 24 hour daily care may not exceed R 420.00 per day (or R 630.00 on a Sunday or R 840.00 on a public holiday) and no other procedure may be charged. 2. In the case of litigation, the registered nurse will be co-responsible for the practice of the enrolled nurse. 3. All services to be re-negotiated with the scheme every 7 days or such lesser period as stipulated in pre-authorisation.	05.03					
CARE OF WOUNDS (The pathology must be stated).							
040	Treatment of simple wounds/burns requiring dressing only.	04.00		8.800	72.00 (63.20)	8.800	72.00 (63.20)
041	Treatment of extensive wounds/bums requiring extensive nursing management eg irrigation, etc.	04.00		12.400	101.50 (89.00)	12.400	101.50 (89.00)
042	Treatment of moderate wounds/Burns eg drains or fistulas and inserting of sutures	04.00		11.000	90.00 (78.90)	11.000	90.00 (78.90)
045	Laser treatment for wound healing where prescribed by medical practitioner	04.00		7.670	62.80 (55.10)	7.670	62.80 (55.10)
RESPIRATORY SYSTEM.							
050	Nebulization/Inhalation.	04.00		3.800	31.10 (27.30)	3.800	31.10 (27.30)
051	Tracheostomy care.	04.00		7.900	64.70 (56.80)	7.900	64.70 (56.80)
052	Peak flow measurement.	04.00		3.100	25.40 (22.30)	3.100	25.40 (22.30)
	For ICU trained nurses registered with SANC as such and nurses working in the occupational health setting but not for a company. (Item 053)	04.00					
053	Flow volume test: inspiration/expiration using ELF/similar machine.	04.00				13.100	107.20 (94.00)
CARDIO-VASCULAR SYSTEM.							
	Only for ICU trained nurses registered as such with SANC. A medical practitioner must be available in the event of a resuscitation being required. (Items 062 and 063).	04.00					
060	Cardiopulmonary resuscitation.	04.00				23.000	188.30 (165.20)
061	Performing ECG only.	04.00				4.600	37.70 (33.10)
062	Effort test - bicycle.	04.00				16.900	138.30 (121.30)
063	Effort test - multistage treadmill.	04.00				38.400	314.30 (275.70)
MUSCULOSKELETAL SYSTEM.							
070	Application or removal splints and prosthesis.	04.00		3.900	31.90 (28.00)	3.900	31.90 (28.00)
071	Application or removal of traction	04.00		7.700	63.00 (55.30)	7.700	63.00 (55.30)
072	Application of skin traction	04.00		7.700	63.00 (55.30)	7.700	63.00 (55.30)
GASTRO INTESTINAL SYSTEM.							
080	Nasogastric tube insertion, feeding and removal.	04.00		9.200	75.30 (66.10)	9.200	75.30 (66.10)
082	Enema administration	04.00		4.800	39.30 (34.50)	4.800	39.30 (34.50)
083	Aspiration of stomach/gastric lavage.	04.00				6.900	56.50 (49.60)
084	Faecal impaction/manual removal.	04.00		8.700	71.20 (62.50)	8.700	71.20 (62.50)
URINARY SYSTEM.							
090	Any urinary tract procedure including catheterisation, bladder stimulation and emptying.	04.00		9.500	77.80 (68.20)	9.500	77.80 (68.20)
091	Condom catheter application, penile dressing, catheter care including bag change or catheter removal.	04.00		5.800	47.50 (41.70)	5.800	47.50 (41.70)
093	Incontinence management (30 minutes) This fee includes intermittent catheterisation, external sheath drainage, taking of history, providing literature and teaching.	04.00		9.500	77.80 (68.20)	9.500	77.80 (68.20)
GENERAL CARE.							
100	This includes all aspects of elementary nursing care performed at a patient's home which may include : Bath/ bedbath, getting patient out of bed, making of bed, hairwash, mouth hygiene, nail care, shave, put patient back to bed, pressure area care, per visit. (irrespective of time spent)	04.00		16.100	131.80 (115.60)	16.100	131.80 (115.60)

Code	Description	Ver	Add	Nursing Agencies/Home Care Services		Registered Nurses	
				RVU	Fee	RVU	Fee
STOMALTHERAPY NURSING.							
	Applicable to stomal therapy trained registered nurses who are working as private practitioners and not for a company other than a registered nursing agency.						05.02
	Please Note: Items 200, 201, 202, 204, 205, 079 and 081 may not be used in conjunction with items 230, 234, 238 and 250						04.00
079	Stomal irrigation - 60 minutes. May not be used in conjunction with the global fees.	04.00		4.800	39.30 (34.50)	4.800	39.30 (34.50)
	Colonic lavage - may be performed by all nurse practitioners but only when prescribed by a medical practitioner, and the written prescription is attached.	04.00					
081	Colonic lavage	04.00		4.800	39.30 (34.50)	4.800	39.30 (34.50)
200	Simple stoma - a well constructed, sited stoma which is easy to pouch. Very little or no peristomal skin excoriation.	04.00		8.800	72.00 (63.20)	8.800	72.00 (63.20)
201	Complex stoma - a poorly constructed, non-sited stoma requiring convexity or build up. Difficult to pouch. Severe peristomal skin excoriation.	04.00		12.400	101.50 (89.00)	12.400	101.50 (89.00)
202	Moderate stoma - a fairly well constructed, sited stoma which may require straight forward convexity or build up. Mild to moderate peristomal skin excoriation.	04.00		11.000	90.00 (78.90)	11.000	90.00 (78.90)
205	Stoma products charged in accordance with rule 05.	04.00		-	-	-	-
230	Global fee - Simple Stoma - Permanent: Includes the following: 1 X Pre-op consultation: includes history, stomal siting, counselling 3 X Post-op consultations - includes checking stoma and pouch, teach, advise on management, diet, lifestyle 2 X Clinic visits plus procedure (remove sutures, check stoma, skin integrity, show/teach other pouches, advise on diet and lifestyle: enema/irrigation/intermittent catheterisation) and materials (gloves, linen saver, gauze etc) 6 Month clinic visit and assessment: including materials (gloves, linen saver, gauze, etc)	04.00		124.900	1022.30 (896.80)	124.900	1022.30 (896.80)
234	Global fee - Moderate Stoma - Permanent (Includes the following): 1 X Pre-op consultation: includes history, stomal siting, counselling 3 X Post-op consultations - includes checking stoma and pouch, teach, advise on management, diet, lifestyle 2 X Clinic visits plus procedure (remove sutures, check stoma, skin integrity, show/teach other pouches, advise on diet and lifestyle: enema/irrigation/intermittent catheterisation) and materials (gloves, linen saver, gauze etc) 6 Month clinic visit and assessment: including materials (gloves, linen saver, gauze, etc)	04.00		137.200	1123.00 (985.10)	137.200	1123.00 (985.10)
238	Global fee: Complex stoma - Permanent (Includes the following): 1 X Pre-op consultation: includes history, stomal siting, counselling 3 X Post-op consultations - includes checking stoma and pouch, teach, advise on management, diet, lifestyle 2 X Clinic visits plus procedure (remove sutures, check stoma, skin integrity, show/teach other pouches, advise on diet and lifestyle: enema/irrigation/intermittent catheterisation) and materials (gloves, linen saver, gauze etc) 6 Month clinic visit and assessment: including materials (gloves, linen saver, gauze, etc)	04.00		159.900	1308.80 (1148.10)	159.900	1308.80 (1148.10)
250	Clinic visits after 6 months per half hour plus one procedure - eg irrigation, enema, etc. - plus material	04.00		10.000	81.90 (71.80)	10.000	81.90 (71.80)
EQUIPMENT							
	Applicable only to registered nurses who are working as private practitioners and not for a company other than a registered nursing agency.						05.02
302	Equipment hire per day, charged according to rule 06.	04.00					
303	Equipment sold to a member should be net acquisition cost. This should be on a separate invoice attached to the account as the cost of these items are refunded to the member, and not paid to the supplier.	05.03		-	-	-	-
MIDWIFERY							
Global Obstetric Fees							
	This is charged where the midwife managed the entire four stages of delivery.						04.00
399	Global midwife delivery fee in hospital / birthing unit. Includes all care from the time of admission of the patient in labour until discharge from hospital.	04.00				210.900	1726.20 (1514.20)
403	Global obstetric fee – home birth. (to be charged if the entire confinement is completed at home). Includes all care from commencement of labour until 1 hour after delivery.	04.00				275.500	2255.00 (1978.10)
407	Global fee for childbirth education. By arrangement with scheme/patient.	04.00				-	-
Where the global fee is not applicable, the following will apply:							
400	First Stage Monitoring	04.00				73.800	604.10 (529.90)