GOVERNMENT NOTICE

DEPARTMENT OF HEALTH

No. 1236 **3 October 2008**

NATIONAL HEALTH ACT, 2003 (ACT NO. 61 OF 2003)

REGULATIONS RELATING TO THE OBTAINMENT OF INFORMATION AND THE PROCESS OF DETERMINATION AND PUBLICATION OF REFERENCE PRICE LISTS

DRAFT REFERENCE PRICE LISTS

The Director-General of the National Department of Health hereby, in terms of regulation 8(1) of the Regulations Relating to the Obtainment of Information and the Process of Determination and Publication of Reference Price Lists (GN R.681 of 23 July 2007), publishes the draft reference price lists for public comment.

Interested persons are requested to submit comments on the draft reference price lists within four weeks of publication of this notice to the Director-General: Health (for the attention of the Director: Health, Financial Planning and Economics) Private Bag X828 Pretoria 0001.

DIRECTOR-GENERAL: HEALTH

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DRAFT SCHEDULES FOR RPL 2009

ACUPUNCTURE AND CHINESE MEDICINE

Acupuncture & Chinese Medicine 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY ACUPUNCTURE & CHINESE MEDICINE PRACTITIONERS WITH EFFECT 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.

RULES

01	All accounts must be presented with the following information clearly stated: - name of the practitioner - qualifications of the practitioner - BHF practice number - Postal address and telephone number - Date on which the service(s) were provided - Applicable item codes - The nature of the treatment - The surname and initials of the member - The first name of the patient - The name of the medical scheme - The membership number of the patient - The name and practice number of the referring practitioner	09.00
02	When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately.	09.00
03	Not more than two separate techniques may be charged for at each session.	09.00
04	The maximum number of acupuncture treatments per course to be charged for is limited to ten. If further treatment is required at the end of this period of treatment, it should be negotiated with the patient.	09.00

ITEMS

1.	**Consultations**				
	Consultation encompasses consultation, history taking, patient examination and assessment, side room diagnostic tests, counseling and/or diagnosis				09.00
Code	**Description**	**Ver**	**Add**	**Chinese Medicine & Acupuncture**	
				RVU	**Fee**
1100	Consultation (up to 15 mins)	09.00		10.000	93.20 (81.80)
1101	Consultation (16-30 mins)	09.00		22.500	209.70 (183.90)
1102	Consultation (31-45 min)	09.00		37.500	349.40 (306.50)
1103	Consultation (46-60 min)	09.00		52.500	489.20 (429.10)
1110	Consultation, each additional full 15 mins beyond 60 mins	09.00		15.000	139.80 (122.60)
2.	**Treatments**				
3100	First treatment (needles, plus maximum of two speciality therapy techniques)	09.00		39.524	368.30 (323.10)
3200	Follow-up treatment (needles, plus maximum of two speciality therapy techniques)	09.00		36.145	336.80 (295.40)
3.	**Speciality Therapy Techniques**				
4010	Moxibustion	09.00		22.770	212.20 (186.10)
4020	Cupping	09.00		19.493	181.60 (159.30)
4030	Dermal needle therapy (plum-blossom or seven-star)	09.00		18.184	169.40 (148.60)
4040	Auricular therapy (micro acupuncture)	09.00		32.146	299.50 (262.70)
4050	Scalp acupuncture	09.00		27.308	254.50 (223.20)
4060	Shilao (diet therapy)	09.00		23.712	220.90 (193.80)
4070	Tui-Na (massage/pressure)	09.00		34.226	318.90 (279.70)

AMBULANCES

Ambulance Services 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR AMBULANCE SERVICES, 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. ALL PRICES ARE VAT EXCLUSIVE.		
Preamble		
It is recommended that, when such benefits are granted, the following should be clearly specified in the scheme's rules: · The limitation, if any, for such benefits.		
REGULATIONS DEFINING THE SCOPE OF THE PROFESSION OF EMERGENCY CARE		
GENERAL RULES		
001	Long distance claims (items 111, 129 and 141) to be rejected unless distance travelled by patient is reflected. Long distance charges may not include item codes 100, 103, 125, 127, 131 or 133. Long distance claims (items 112, 130 and 142) to be rejected unless the distance is reflected. Long distance charges may not include item codes 100, 103, 125, 127, 131 or 133.	04.00
002	No after hours fees may be charged	04.00
003	Item code 151 may only be charged for services provided by a second vehicle (either ambulance or response vehicle) and shall be accompanied by a motivation.	04.00
004	Guidelines for information required on each account : · Name of service · BHF practice number · Address · Telephone number · Pre-authorisation number · The name of the member · The name of the patient · The name of the medical scheme · The membership number of the member · 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 the National Reference Price List.	04.00
005	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
006	A BLS service (Practice type "51200") may not charge for ILS or ALS, an ILS service (Practice type "51100") may not charge for ALS. An ALS service (Practice type "51000") may charge all codes.	05.04
Definitions 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	04.00

Code	Description	Ver	Add	Ambulance Services : Advanced Life Support		Ambulance Services : Intermediate Life Support		Ambulance Services : Basic Life Support	
				RVU	Fee	RVU	Fee	RVU	Fee
	(CCA and NDIP) whilst patient in transport. This includes all incubated neonatal transfers. NOTES: Incubator transfers require ALS trained personnel in accordance with the HPCSA ruling If a hospital or the attending physician requires a Paramedic to accompany the patient on a transfer in the event of the patient needing ALS intervention the doctor requesting the Paramedic must write a detailed motivational letter in order for ALS to be charged. If a hospital or the attending physician requires a Paramedic to accompany the patient on a transfer in the event of the patient needing ILS intervention the doctor requesting the Paramedic must write a detailed motivational letter in order for ILS to be charged. In order to bill as an advanced life support call, a registered advanced life support provider must have examined, treated and monitored the patient while in transit to hospital. In order to bill as an intermediate life support call, a registered intermediate life support provider must have examined, treated and monitored the patient while in transit to hospital. Where an ALS provider is in attendance at a callout but does not do any interventions at an ALS level on the patient or ALS monitoring and presence is not required, the billing will be based on a lower level dependent on the care given to the patient. (e.g. Paramedic sites IV line or nebulises patient with a B agonist - this falls within the practice of an AEA and thus is to be billed as an ILS call not an ALS call) Where an ILS provider is in attendance at a callout but does not do any interventions at an ILS level on the patient or ILS monitoring and presence is not required, the billing will be BLS. Where the management undertaken by a paramedic or AEA fall within the scope of practice of a BAA the call must be at a BLS level Please Note : The amounts reflected in the NRPL for each level of care is inclusive of any disposables (except for pacing pads, heimlich valves, high capacity giving sets, dial a flow, intra-osseous needles) and drugs used in the management of the patient, as per attached nationally approved medication protocols. Haemaccel and colloid solution may be charged separately. [illegible] required for such a transport and what medical assistance the patient requires on route.								
DEFINITION: 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.								04.00

Code	Description	Ver	Add	Ambulance Services : Advanced Life Support		Ambulance Services : Intermediate Life Support		Ambulance Services : Basic Life Support	
				RVU	Fee	RVU	Fee	RVU	Fee
	3. Should a response vehicle go to a scene and not render any ALS treatment then the said response vehicle may not levy a bill. 4. Notwithstanding that, item 151 applies to all ALS resuscitation per the notes in this schedule Response vehicle only - Intermediate Life Support (ILS) A clear definition must be drawn between the acute primary response and a booked call. 1. The Acute Primary Response is defined as follows: A call that is received for medical assistance to a member of the public who is ill or injured at work, home or in a public area e.g. motor vehicle accident. Should an ILS response vehicle be dispatched to the scene of the emergency and the patient is in need of Intermediate Life Support and which is rendered by ILS Personnel e.g. AEA, the respective service shall be entitled to bill on item 125, for such service. However, the service which is transporting the patient shall not be able to levy a bill, as the cost of transportation is included in the ILS rate (refer 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	05.04		171.276	832.80	171.276	832.80	171.276	832.80
102	Up to 60 minutes	05.04		228.156	1109.40	228.156	1109.40	228.156	1109.40
103	Every 15 minutes thereafter or part thereof, where specially motivated	05.04		57.084	277.60	57.084	277.60	57.084	277.60
Long distance									
111	Per km (> 100 km) DISTANCE TRAVELLED BY PATIENT	05.04		2.843	13.80	2.843	13.80	2.843	13.80
112	Per km (> 100 km) (BLS return - non patient carrying kilometres) to a maximum of R1986.40	06.02		1.000	4.86	1.000	4.86	1.000	4.86
2	**INTERMEDIATE LIFE SUPPORT**								
Metropolitan area									
125	Up to 45 minutes	05.04		231.226	1124.30	231.226	1124.30	-	-
127	Every 15 minutes thereafter or part thereof, where specially motivated	05.04		77.075	374.80	77.075	374.80	-	-
Long distance									
129	Per km (> 100 km) DISTANCE TRAVELLED BY PATIENT	05.04		3.850	18.70	3.850	18.70	-	-
130	Per km (> 100 km) (ILS return - non patient carrying kilometres) to a maximum of R1986.40	06.02		1.000	4.86	1.000	4.86	-	-
3	**ADVANCED LIFE SUPPORT / INTENSIVE CARE UNIT**								
Metropolitan area									
131	Up to 60 minutes	05.04		406.641	1977.20	-	-	-	-
133	Every 15 minutes thereafter or part thereof, where specially motivated.	05.04		101.660	494.30	-	-	-	-
Long distance									
141	Per km (> 100 km) DISTANCE TRAVELLED BY PATIENT	05.04		5.072	24.70	-	-	-	-

STAATSKOERANT, 3 OKTOBER 2008

No. 31469 11

Code	Description	Ver	Add	Ambulance Services : Advanced Life Support		Ambulance Services : Intermediate Life Support		Ambulance Services : Basic Life Support	
				RVU	Fee	RVU	Fee	RVU	Fee
142	Per km (> 100 km) (ALS return - non patient carrying kilometres) to a maximum of R1986.40	06.02		1.000	4.86	-	-	-	-
4	**ADDITIONAL VEHICLE OR STAFF FOR INTERMEDIATE LIFE SUPPORT, ADVANCED LIFE SUPPORT AND INTENSIVE CARE UNIT**								
151	Resuscitation fee, per incident	04.00		454.000	2207.50	454.000	2207.50	-	-
153	Doctor per hour	04.00		130.000	632.10	130.000	632.10	-	-
	Note : A resuscitation fee may only be billed when a second vehicle (response car or ambulance) with staff (inclusive of a paramedic) attempt to resuscitate the patient using full ALS interventions These interventions must include one or more of the following: · Administration of advanced cardiac life support drugs. · Cardioversion-synchronised or unsynchronised (defibrillation) · External cardiac pacing · Endotracheal intubation (oral or nasal with assisted ventilation	04.00							
	Note : Where a doctor callout fee is charged the name and HPCSA registration number and BHF practise number of the doctor must appear on the bill.								04.00
5.	**AEROMEDICAL TRANSFERS**								
	BY ARRANGEMENT WITH MEDICAL SCHEME								04.00
Rotorwing Rates									
	Definitions: 1. Helicopter rates are determined according to aircraft type 2. Day light operations are defined from Sunrise to Sunset (and night operations from Sunset to Sunrise) 3. If flying time is mostly in night time (as per definition above), then bill night time operation rates (type C) 4. Call out charge includes Basic Call Cost plus other flying time incurred, Staff and consumables cost can only be charged if a patient has been treated. 5. Flying time is billed for minimum of 30 minutes and thereafter in 15 minute increments. 6. A 2nd Patient is transferred at 50% reduction of Basic Call and Flight cost, but Staff and Consumables costs remain per patient. (Only if aircraft capability allows for multiple patients) 7. Rates are calculated according to time; from throttle open, to throttle closed. 8. Group A - C must fall within the Cat 138 Ops as determined by Civil Aviation. 9. Hot loads restricted to 8 minutes ground time and must be denoted.								04.00
	AIRCRAFT TYPE A (RA) HB206L, HB204 / 205, HB407, AS360, EC120, MD600, AS350, A119 AIRCRAFT TYPE B (RB) & Ca (DAY OPERATIONS) (RC) BO105, 206CT, AS355, A109 AIRCRAFT TYPE Cb (NIGHT OPERATIONS) (RC) HB222, HB212 / 412, AS365, S76, HB427, MD900, BK117, EC135, BO105 AIRCRAFT TYPE D (RESCUE) H500, HB206B, AS350, AS315, FH1100								04.00
500	Basic Call Cost (Start up)	04.00							
Flying Time									
531	30 minutes	04.00							
533	45 minutes	04.00							
535	60 minutes	04.00							
537	75 minutes	04.00							

Code	Description	Ver	Add	Ambulance Services : Advanced Life Support		Ambulance Services : Intermediate Life Support		Ambulance Services : Basic Life Support	
				RVU	Fee	RVU	Fee	RVU	Fee
539	90 minutes	04.00							
541	105 minutes	04.00							
543	120 minutes	04.00							
Staff and Consumables									
581	30 minutes	04.00							
583	45 - 75 minutes	04.00							
585	90 - 105 minutes	04.00							
587	120 minutes	04.00							
Aircraft Type D									
591	Hourly rate plus 20%	04.00							
Winching									
595	Winching, per lift	04.00							
Fixed Wing Rates									
	DEFINITIONS: 1. Group A must fall within the Cat 138 Ops as determined by Civil Aviation. 2. 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. The definition of use of these aircraft needs to be narrowed down further to eliminate abuse. 3. Staff and consumables cost can only be used if patient has been treated. 5. 2nd patient transferred at 50% reduction of Basic Call and Flight Cost, but Staff and consumables costs remain per patient. (only if aircraft capability allows for multiple patients)								04.00
Group A (FA)									
	Composed of flying cost per kilometer, staff cost per hour and equipment cost								04.00
Staff cost per hour									
621	Doctor	04.00							
623	ICU Sister	04.00							
625	Paramedic	04.00							
Equipment Cost									
631	Per patient, per hour	04.00							
Aircraft cost (per kilometer)									
651	Beechcraft Duke	04.00							
653	Lear 24F	04.00							
655	Lear 35	04.00							
657	Falcon 10	04.00							
659	King Air 200	04.00							
661	Mitsubishi MU2	04.00							
663	Cessna 402	04.00							
665	Beechcraft Baron	04.00							
667	Citation II	04.00							
669	Pilatus PC12	04.00							

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

BIOKINETICS

Biokinetics 2009

DRAFT NATIONAL REFERENCE PRICE LIST IN RESPECT OF BIOKINETICS WITH EFFECT 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.

GENERAL RULES

002	The consultation code may be charged only once at the same consultation or visit. Consultation includes history taking, guidance, education, health promotion and/or consultation	04.00
003	A maximum of three diagnostic procedures may be charged at the same consultation or visit. Diagnostic procedures include the full range of diagnostic and evaluation procedures within the scope of practice of the biokineticist, including for example: anthropometric / body composition assessments, ergological testing evaluations and perceptual motor evaluation.	05.06
004	A maximum of three treatment procedures may be charged at the same consultation or visit for any single diagnosis. This limitation shall be inclusive of a maximum of one group treatment procedure (code 12), where applicable. Treatment procedures include the full range of rehabilitative or preventive treatment or care procedures within the scope of practice of the biokineticist, including for example: hydrotherapy, callisthenics exercises and programme prescription for individuals with CHD.	04.00
005	After a series of 12 treatments in respect of one patient for the same condition, the practitioner concerned shall report to the scheme as soon as possible if further treatment is necessary. Further continuance of treatment should only be considered if recommended by the medical practitioner(s) and others involved in the rehabilitation of the patient.	04.00
010	Every biokineticist must acquaint himself with the provisions of the Medical Schemes Act, 1998 and the regulations promulgated under the Act in connection with the rendering of accounts. Every account shall contain the following particulars: · The name and practice code number of the referring practitioner. · The name of the member. · The name of the patient. · The name of the medical scheme. · The membership number of the member. · The date on which the service was rendered. · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered	04.00
011	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

ITEMS

Code	Description	Ver	Add	Biokinetics RVU	Biokinetics Fee
1.	**Consultations / Patient Education / Counseling**				
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	04.00		-	-
901	Initial consultation including: a problem focused history; a short problem focused examination; and straightforward biokinetic decision making; but excluding evaluation. To be charged only once per course of treatment. (inclusive of lung function tests)	06.01		16.700	69.80 (61.20)
903	Subsequent consultation for the same condition (global fee covering a problem focused interval history and re-examination; and straightforward biokinetic decision making but excluding physical re-assessment). To be charged only once per course of treatment.	06.01		11.700	48.90 (42.90)
905	Consultation at hospital (global fee including a problem focused history; a problem focused examination; and biokinetic decision making excluding evaluation and physical re-assessment of a patient). To be charged only once per course of treatment	06.01		16.700	69.80 (61.20)
922	Patient education (based upon the evaluation outcomes)	06.01		16.300	68.10 (59.70)
936	Health promotion and lifestyle modification	06.01		-	-
2.	**Evaluation / Diagnostic Procedures**				
908	Simple evaluation at the first visit only (to be fully documented)	06.01		10.000	41.80 (36.70)
909	Complex evaluation at the first visit only (to be fully documented).	06.01		16.700	69.80 (61.20)
912	Anthropometric/body composition assessment	06.01		10.000	41.80 (36.70)
913	Ergological testing evaluation of body segment, limb or joint	06.01		28.500	119.10 (104.50)

Code	Description		Ver	Add	Biokinetics	
					RVU	Fee
914	Neurological patients: Ergological evaluation		06.01		16.700	69.8 (61.2(
915	Postural analysis and/or analysis of activities of daily living, gait and specific motor ac		06.01		16.700	69.8 (61.2(
916	Perceptual motor evaluation (perception and gross motor function)		06.01		16.700	69.8 (61.2(
917	Physical work capacity (treadmill or bicycle ergometer/other electronic equipment) / M assessment (strength, endurance range of motion, posture)	uloskeletal	06.01		28.500	119.1 (104.5(
918	Physical work capacity with full ECG		06.01		28.500	119.1 (104.5(
920	Isotonic, isometric or EMG testing by means of specialised electronic equipment		06.01		28.500	119.1 (104.5(
921	Isokinetic testing by means of specialised electronic equipment		06.01		28.500	119.1 (104.5(
3.	**Therapeutic Procedures (Physical Rehabilitation)**					
	Maximum of 3 modalities, per diagnosis, may be charged per visit					04.0(
923	Proprioception, balance and motor co-ordination exercise therapy session with or wit	equipment	06.01		16.300	68.1 (59.7(
925	Hydrotherapy where the condition of the patient is such that it requires the undivided Biokineticist	ition of the	06.01		16.300	68.1 (59.7(
926	Exercise on Isokinetic apparatus/Isotonic/Isometric resistance equipment.		06.01		16.300	68.1 (59.7(
927	Posture, gait and activities of daily living (ADL), with/without equipment use		06.01		16.300	68.1 (59.7(
928	A rehabilitative exercise prescription		06.01		16.300	68.1 (59.7(
929	Callisthenics exercises		06.01		16.300	68.1 (59.7(
930	Group session with high risk patients per patient (maximum 10 patients)		06.01		8.800	36.8 (32.3(
931	Passive and active range of motion exercise therapy		06.01		16.300	68.1 (59.7(
933	Programme prescription for an individual with CHD health risks including hyperlipidae metabolic disorders, Low-Back pain/ Lumbago etc.		06.01			
934	Group exercise sessions, per patient		06.01		8.800	36.8 (32.3(

CHIROPRACTORS

Chiropractors 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY CHIROPRACTORS 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.

GENERAL RULES

001	All accounts must be presented with the following information clearly stated: · name of chiropractor; · qualifications of the chiropractor; · BHF practice number; · postal address and telephone number; · date on which service(s) were provided; · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered; · the surname and initials of the member; · the first name of the patient; · the name of the scheme; · the membership number of the member; · a statement of whether the account is in accordance with the National Reference Price List; and · the name and practice number of the referring practitioner, if applicable.	04 00
002	The consultation code may be charged only once at the same consultation or visit Consultation includes history taking, guidance, education, health promotion and/or consultation.	04 00
003	A maximum of three diagnostic procedures may be charged at the same consultation or visit. Diagnostic procedures include physical examination, neurological examination, orthopaedic examination, ergonomical analysis, postural analysis and radiological examination	05 06
004	A maximum of three treatment procedures may be charged at the same consultation or visit for any single diagnosis. Treatment procedures include inter alia: spinal or extra-spinal manipulation, acupuncture, cold applications, non-heating modalities, deep heating radiation, soft tissue manipulation, superficial heating therapy and therapeutic exercises (other than in relation to preparation or fitting of appliances).	05 02
005	After a series of 12 treatments in respect of one patient for the same condition, the practitioner concerned shall report to the scheme as soon as possible if further treatment is necessary. Payment for treatment in excess of the stipulated number may be granted by the scheme after receipt of a letter from the practitioner concerned, motivating the need for such treatment.	05 03
006	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.	05 03

MODIFIERS

CHIROPRACTORS RECOMMENDED REIMBURSEMENT RATES

Code	Description	Ver	Add	Chiropractice RVU	Chiropractice Fee
1	**Consultations**				
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	05.02			
301	Consultation	05.03		25.000	106.10 (93.10)
2	**Diagnostic procedures**				
	Only a single item from this section may be charged per patient encounter				05 03
	Radiation Control Council Certificate number to be on account if X-Rays charged				04 00
311	Single diagnostic procedure	05.03		25.000	106.10 (93.10)
312	Two diagnostic procedures	05.03		37.500	159.20 (139.60)
313	Three diagnostic procedures	05.05		50.000	212.30 (186.20)
3	**Immobilisation or therapeutic exercises in relation to preparation or fitting of appliances**				
	Only a single item from this section may be charged per patient encounter				05 03
321	Single instance of immobilization or therapeutic exercises	05.03		10.000	42.50 (37.30)
322	Two instances of immobilization or therapeutic exercises	05.03		15.000	63.70 (55.90)
4	**Treatment (therapeutic procedures)**				
	Only a single item from this section may be charged per patient encounter				05 03

Code		Description	Ver	Add	Chiropractice	
					RVU	Fee
331	Single treatment procedure		05.03		10.000	42.50 (37.30)
332	Two treatment procedures		05.03		15.000	63.70 (55.90)
333	Three treatment procedures		05.03		20.000	84.90 (74.50)
334	Four treatment procedures		05.03		25.000	106.10 (93.10)
335	Five treatment procedures		05.03		30.000	127.40 (111.80)
336	Six treatment procedures		05.03		35.000	148.60 (130.40)
5	**Consumables**					
	The amount charged in respect of medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965). In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus - * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.					05.03
100	Medication / material: Charge for medication or material, identified by the appropriate Nappi code.		05.06		-	-
110	X-Ray films		06.00		-	-

CLINICAL TECHNOLOGISTS

Clinical Technologists 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY CLINICAL TECHNOLOGISTS WITH EFFECT 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.

GENERAL RULES

001	It is recommended that, when such benefits are granted, drugs, consumables and disposal 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	Fee prorated according to number of treatment days;. fee = ([number of treatment days] / 30) x (item fee)	05.03

ITEMS

Surgical Support

Code	Description	Ver	Add	Clinical Technology RVU	Clinical Technology Fee
010	Ablations	04.00		219.700	1812.50 (1589.90)
011	Preparation of extra-corporeal equipment for surgical procedures.	04.00		196.700	1622.80 (1423.50)
012	Operation of heart laser during myocardial revascularisation	04.00		219.700	1812.50 (1589.90)
013	Continued operation of extra-corporeal equipment during surgery for a time in excess of one hour in 30 minute increments or part thereof provided that such part comprises 50% or more of the time	04.00		20.300	167.50 (146.90)
014	Radiofrequency Catheter Ablations	04.00		219.700	1812.50 (1589.90)
	Not to be charged with item 012	05.03			
015	Preparation and operation of pre-operative intra-operative or post operative physiological monitoring per patient, per admission	04.00		19.400	160.10 (140.40)
	May only submit once in theatre and once in catheterisation laboratory	05.03			
017	Standby with extra-corporeal equipment for surgery within hospital	04.00		58.800	485.10 (425.50)
	Cannot be used with 011	05.03			
019	Standby within the hospital for coronary angioplasty.	04.00		19.400	160.10 (140.40)
021	Preparation and operation of intra-aortic balloon pump in theatre, intensive care unit and catheterisation laboratory.	04.00		58.800	485.10 (425.50)
085	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time.	04.00		10.000	82.50 (72.40)
023	Global fee for preparation and operation and removal of cardio assist device (LVAD, RVAD or BiVAD) in theatre and intensive care unit.	04.00		196.700	1622.80 (1423.50)
027	Preparation and operation of a pre- and post-operative blood salvage device.	04.00		19.400	160.10 (140.40)
029	Preparation and operation of an autotransfusion cell washing system.	04.00		77.100	636.10 (558.00)
031	Determination and monitoring of haemodynamic/pulmonary parameters, metabolism, arterio-venous pressure flow studies in high care/ICU (per patient per multiple procedures per day)	04.00		61.700	509.00 (446.50)
033	Assistance with bronchoscopy procedures, placement of arterial/venous catheters, ultrasound examinations or photography.	04.00		14.600	120.50 (105.70)
034	Lymph compression treatment.	04.00		22.500	185.60 (162.80)
116	Preparation and operation of an artificial heart (Berlin-Heart)	04.00		219.700	1812.50 (1589.90)
118	Daily monitoring of artificial heart, per hour	04.00		33.400	275.60 (241.80)
157	Standby with extra corporeal equipment (maximum 4 hours) (per event).	04.00		26.300	217.00 (190.40)

Pulmonology

	Items 035 to 061 apply only to outpatient, casualty department and normal wards - Not high care or intensive care, except item 050 which applies to intensive care only.				04.00
035	Nebulization (per one procedure).	04.00		12.300	101.50 (89.00)
037	Measurement of Lung volumes and capacities by means of closed circuit (He) or (N2) washout or body plethysmography.	04.00		24.200	199.70 (175.20)

Code	Description	Ver	Add	Clinical Technology	
				RVU	Fee
039	Flow-volume determinations.	04.00		30.600	252.50 (221.50)
041	Flow-volume (Pre-post B-D).	04.00		50.800	419.10 (367.60)
043	Airways resistance and conductance measurements using plethysmograph or similar apparatus.	04.00		24.200	199.70 (175.20)
045	Gas distribution measurements	04.00		24.200	199.70 (175.20)
047	Diffusion determinations.	04.00		24.200	199.70 (175.20)
049	Exercise testing (EIA).	04.00		17.100	141.10 (123.80)
050	ECMO change-out and re-establishment.	04.00		46.300	382.00 (335.10)
051	Exercise testing with recording of VT, VO2, HR, RR, ECG and Oximetry	04.00		24.200	199.70 (175.20)
053	Allergy tests.	04.00		11.400	94.10 (82.50)
055	If RAST included add (per allergen).	04.00	+	11.400	94.10 (82.50)
057	Bronchial provocation testing	04.00		40.800	336.60 (295.30)
059	Compliance measurements.	04.00		24.200	199.70 (175.20)
061	Maximum inspiratory (MIP) and/or expiratory (MEP) pressures and/or Vital Capacity and/or PEFR.	04.00		6.000	49.50 (43.40)
Cardiology					
062	Assist in preparations and operations of Rotablator Procedures	04.00		29.900	246.70 (216.40)
063	Cardiac catheterisation for the first hour.	04.00		40.300	332.50 (291.70)
065	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		10.000	82.50 (72.40)
064	Intravascular Ultrasound (IVUS	04.00		25.700	212.00 (186.00)
	This fee can only be charged once, irrespective of how many times this procedure is repeated. The technologist cannot charge for this procedure if a representative of a company or any other person is operating the IVUS machine	05.03			
068	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time.	04.00		10.000	82.50 (72.40)
066	Cardiac Cath Right Heart Studies	04.00		56.000	462.00 (405.30)
067	Cardiac Electro physiology and related procedures for first FOUR hours.	04.00		67.900	560.20 (491.40)
069	Temporary and single Pacemaker procedures.	04.00		40.300	332.50 (291.70)
070	Permanent and dual Pacemaker procedures or implantation and testing of ICD devices.	04.00		46.300	382.00 (335.10)
	Not to be charged in conjunction with items 063 or 065	05.03			
071	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time.	04.00		10.000	82.50 (72.40)
072	Multisite Pacing (Bi-ventricular pacing)	04.00		46.300	382.00 (335.10)
073	Dilatation procedures and stents	04.00		55.400	457.10 (401.00)
074	Wavemap - Measurement of Fractional Flow Reserve to assess the functional severity of coronary artery stenoses	04.00		10.000	82.50 (72.40)
075	Pacemaker checking and/or reprogramming.	04.00		14.000	115.50 (101.30)
077	24 Hour Holter ambulatory monitoring.	04.00		55.400	457.10 (401.00)
079	Cardiac exercise stress testing	04.00		29.100	240.10 (210.60)
081	Recording of twelve lead ECG	04.00		7.700	63.50 (55.70)
087	M Mode echocardiogram.	04.00		16.600	137.00 (120.20)
089	2D echocardiogram.	04.00		29.400	242.60 (212.80)
091	Doppler flow.	04.00		32.300	266.50 (233.80)

Code	Description	Ver	Add	Clinical Technology	
				RVU	Fee
093	Colour imaging.	04.00		32.300	266.50 (233.80)
095	ECG signal averaging (Hi-Res).	04.00		53.700	443.00 (388.60)
097	Ambulatory bloodpressure monitoring.	04.00		18.600	153.50 (134.60)
099	Vector cardiogram.	04.00		55.400	457.10 (401.00)
111	Transoesophageal echocardiogram	04.00		43.100	355.60 (311.90)
Neurology					
	Preparation, recording and analyses technical report of:				04.00
178	Short latency brainstem auditory evoked potentials, neurological examination, bilateral	05.03		74.100	611.30 (536.20)
179	Auditory evoked potentials, full audiological examination, bilateral	05.03		74.100	611.30 (536.20)
180	Pattern-reversal visual evoked potentials: full evaluation of visual pathways, unilateral	05.03		37.110	306.20 (268.60)
181	Somatosensory evoked potentials, unilateral, upper limb	05.03		37.110	306.20 (268.60)
182	Somatosensory evoked potentials, unilateral, lower limb	05.03		37.110	306.20 (268.60)
115	Additional 2 nerves (used as adjunct with nerve conduction studies, including F-waves, H-reflexes or additional nerves required for diagnosis)	04.00		14.900	122.90 (107.80)
117	Electroretinography (ERG) - unilateral or Electro-oculography (EOG)	04.00		43.100	355.60 (311.90)
183	Electronystagmography for spontaneous and positional nystagmus (3253)	05.03		24.150	199.20 (174.70)
184	Caloric test done with electronystagmography (3255)	05.03		67.570	557.50 (489.00)
119	Sleep EEG.	04.00		31.400	259.10 (227.30)
185	Overnight polysomnography	05.03		264.830	2184.80 (1916.50)
186	Obstructive sleep apnea screening	05.03		137.170	1131.70 (992.70)
187	Long term EEG monitoring with a minimum of 8 hours (but less than 16 hours) recording time, including preparation (collodion adhesive technique with at least 21 electrodes) and interpretation	05.03		137.890	1137.60 (997.90)
188	Long term EEG monitoring with 16 to 24 hours recording time, including preparation (collodion adhesive technique with at least 21 electrodes) and interpretation	05.03		264.830	2184.80 (1916.50)
125	Multiple sleep latency test (MSLT	04.00		111.100	916.60 (804.00)
127	Overnight CPAP titration.	04.00		104.200	859.70 (754.10)
132	Mobile EEG setup in ICU (to be added to Item 133 if appropriate)	05.02	+	17.420	143.70 (126.10)
133	EEG with special activation.	04.00		49.400	407.60 (357.50)
135	Electromyography : Needle examination per muscle/conduction velocity (motor/sensory) each, to a maximum of 5.	04.00		14.900	122.90 (107.80)
137	Intra-operative evoked potentials for the 1st hour	04.00		55.400	457.10 (401.00)
139	Each additional hour or part thereof provided that such part comprises 50% or more of the time.	04.00		37.100	306.10 (268.50)
141	Intra-operative EEG (carotid endarterectomy).	04.00		26.300	217.00 (190.40)
143	Transcranial or Carotid Doppler (bilateral).	04.00		39.400	325.10 (285.20)
Dialysis					
145	Preparation of extra-corporeal equipment: Haemoperfusion (HP), Haemofiltration (HF), Haemoconcentration (HC), Continuous renal replacement therapy (CRRT), Aphaeresis, Auto transfusion and cell recovery (AT	04.00		46.300	382.00 (335.10)
146	Chronic haemodialysis (acetate dialysate)	04.00		149.400	1232.60 (1081.20)
148	Chronic haemodialysis (bicarbonate dialysate)	04.00		159.600	1316.70 (1155.00)
	In the case of items 146 and 148, routine outpatient dialysis includes dialyser, bloodlines, acetate dialysate, priming set, sodium heparin, anticoagulant, saline infusion, dressing pack, fistula needles/catheter dressing, syringes and needles, cleaning materials, equipment set-up, up to 5 hours treatment time, equipment rental	05.03			

Code	Description	Ver	Add	Clinical Technology RVU	Clinical Technology Fee
147	Peritoneal dialysis, per day	04.00		16.800	138.60 (121.60)
	The global fees for Continuous Ambulatory Peritoneal Dialysis (CAPD) (Item 176) and Automated Peritoneal Dialysis (APD) (Item 177) include: consumables; cost of machine and machine disposables; professional fee; initial training; in-centre follow-up visits; and home visits. However, they exclude Tenckhoff catheter and insertion thereof; and disposables required for a transfer set change (usually 6 monthly). These fees are chargeable for each 30 day cycle in which CAPD or APD is provided. If CAPD or APD is provided for less than a 30 days in any one cycle (for example due to complications or death of the patient): a. if the period of treatment is 26 days or more in that cycle, the full fee applies; b. if the period of treatment is up to 25 days in that cycle, the fee should be prorated according to number of actual treatment days. Modifier 0001 should be quoted, and number of treatment days specified.	05.03			
176	Global fee for Continuous Ambulatory Peritoneal Dialysis (CAPD), per 30 day period	05.03		1700.000	14025.00 (12302.60)
177	Global fee for Automated Peritoneal Dialysis (APD), per 30 day period.	05.03		2360.000	19470.00 (17078.90)
149	Treatment procedure per 1 hour (excluding acute haemodialysis, chronic haemodialysis and CRRT)	04.00		33.400	275.60 (241.80)
150	Acute haemodialysis	04.00		317.200	2616.90 (2295.50)
	Emergency dialysis treatment in hospital; includes dialyser, bloodlines, acetate/bicarbonate dialysate, priming set, equipment set-up, up to 5 hours treatment time, equipment rental	05.03			
151	Treatment procedures for CRRT up to 6 hours or part thereof provided that such part comprises 50% or more of the time	04.00		24.800	204.60 (179.50)
152	Treatment procedure for CRRT up to 12 hours or part thereof provided that such part comprises more than 6 hours of the time	04.00		49.700	410.00 (359.60)
154	Treatment procedure for CRRT up to 18 hours or part thereof provided that such part comprises more than 12 hours of the time	04.00		74.500	614.60 (539.10)
156	Treatment procedure for CRRT up to 24 hours or part thereof provided that such part comprises more than 18 hours of the time	04.00		99.300	819.20 (718.60)
153	Patient training in centre for dialysis, CPAP training and problem-solving, home ventilators and nebulisers, per 30 minutes (to maximum of 24 hours)	04.00		16.600	137.00 (120.20)
155	Patient training or follow-up at patient's home, for dialysis, home ventilators and nebulisers, per 30 minutes (to maximum of 24 hours)	04.00		29.100	240.10 (210.60)
Reproductive Health					
	As schemes will not necessarily grant benefits in respect of some items below, they fall into the "By arrangement with the scheme" category				04.00
159	Post Vasectomy semen analysis	04.00		10.000	82.50 (72.40)
161	Complete semen analysis.	04.00		31.700	261.50 (229.40)
163	Semen wash for A I.	04.00		30.300	250.00 (219.30)
165	IVF, GIFT, PROST with semen and serum preparation including ovum and embryo handling and transfer	04.00		368.700	3041.80 (2668.20)
	Cannot be used with items 161, 163, 167 and 169	05.03			
167	Ovum and embryo freezing.	04.00		131.300	1083.20 (950.20)
169	Semen freezing.	04.00		30.300	250.00 (219.30)
Miscellaneous					
171	Travelling per km in excess of 16km (in own car).	04.00		0.675	5.57 (4.89)
173	Equipment hire (By arrangement with scheme).	04.00		-	
175	Medication / Material	04.00		-	
	The amount charged in respect of medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004 made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965). In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus - * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.	05.03			

DENTAL PRACTITIONERS

Dental Practitioners 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY DENTAL PRACTITIONERS, 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.

The existence of a code in this publication does not mean that the procedure will be reimbursed by medical schemes. Medical schemes have the right to limit the scope, the frequency and/or combinations of dental procedures that is covered or reimbursed. It is the responsibility of the patient to know what procedures are covered and what are excluded from his/her dental benefit plan, and not that of the dental office. Certain medical schemes may require predetermination for particular procedures and/or when charges are expected to exceed a certain amount.

The schedule includes procedures and services for use by Oral Health Care Providers for purposes of keeping accurate patient records, reporting procedures on patients, and processing oral health care related insurance claims. The procedures are those performed by general dental practitioners, oral pathologists, prosthodontists, periodontists, orthodontists, maxillo-facial and [illegible] prosthetists

under the category of service with which the procedures are most frequently identified and should not be interpreted as excluding certain categories of Oral Health Care Providers from performing such procedures. For the convenience in using the schedule, been divided into categories of services, based on the branches of clinical dental practice. The procedures are grouped Individual procedure codes consist of a procedure code, procedure description (nomenclature), and when necessary, a descriptor, that provides further definition and/or guidelines to clarify the intended use of the procedure code.

I.	**INTRODUCTION**	
A.	**Administrative and invoicing rules**	
001	Invoices:	
	a. A practitioner shall render a monthly invoice for every procedure which has been completed irrespective of whether the total treatment plan has been concluded.	05.02 05.02
	b. An invoice shall contain the following particulars:	05.02
	i. The surname and initials of the member; ii. The first name of the patient; iii. The name of the scheme; iv. The membership number of the member; v. The practice number; vi. The date on which every service was rendered; vii. The code number, description and fee/benefit of the procedure or service viii. The name of the dentist rendering the service ix. The name of the general dental practitioner/specialist assistant (when applicable), x. The appropriate ICD-10 code(s) for the procedures performed.	06 03
	Note: Photocopies of original invoices shall be certified by way of a rubber stamp or the signature of the dentist.	05.02
002	Cost of direct materials: The expenses incurred for direct materials identified in the Schedule may be billed in addition to the procedure code. These expenses are limited to the net acquisition cost of the materials and a handling fee. The price of the materials should be VAT inclusive. Use Modifier 8025 for handling fee.	05.02
003	Dental laboratory services:	05.02
	Manual submission of invoices. Fees charged by dental technicians for laboratory services (PLUS L) shall be indicated on the dentist's invoice by reporting code 8099 - Dental laboratory service with the appropriate laboratory fee on the line following the relevant dental procedure code The technician's invoice shall be certified by the dentist (or a person appointed by the dentist) for correctness by means of a signature. The original invoice of the dental technician (or a copy thereof) shall accompany the invoice of the dentist and a copy (or the original) shall be filed by the dentist for record purposes.	05.02