Code	Description	Ver	Dental Therapy	MP	Lab	TC
	Eight and more radiographs of any combination of Codes 8107 and 8112 taken on the same date of service for diagnostic purposes are considered to be a complete intraoral series (8108) and should be submitted as such.					
8113	Intraoral radiograph - occlusal	04.00	83.50 (73.20)			B
8114	Extraoral radiograph - hand-wrist	06.03	-			B
	Use to report extraoral radiographs such as hand-wrist radiographs.					
8115	Extraoral radiograph - panoramic	04.00	194.20 (170.40)			B
8116	Extraoral radiograph - cephalometric	05.02	194.20 (170.40)			B
8118	Extraoral radiograph - skull/facial bone	05.02	-			B
8121	Oral and/or facial image (digital/conventional)	06.03	52.10 (45.70)			B
	This includes traditional photographs and digital intra- or extraoral images obtained by intraoral cameras. These images should only be reported when taken for clinical/diagnostic reasons and shall be retained as part of the patient's clinical record. Excludes conventional radiographs.					
Preventive services						
	Note : Items 8159, 8155, 8161 and 8162 may not be charged more than once in six months per patient. Where item 8159 is applied, item 8155 may not be charged. Item 8151 and 8153 may not be charged to patients under 9 years of age.	06.03				
8151	Oral hygiene instruction	06.03	50.80 (44.60)			B
	The dental knowledge of the patient/parent to prevent oral diseases should be evaluated before oral hygiene instructions is provided e.g., do they know what is dental plague, how can it be removed, what is fluoride, how does fluoride work to prevent dental caries, how can fluoride be used and what is a dental sealant. An oral hygiene instruction may include, but is not limited to: Plaque control information, e.g. instruction pamphlets or leaflets; Dietary instructions; Explanation and demonstration of plaque control (brushing and flossing); Self-practice session in the mouth under professional supervision; Use of special aids such as disclosing agents; and Scoring of plaque levels (plaque index). The patient must be informed prior to the service being rendered that a fee will be levied for oral hygiene instruction. Oral hygiene instructions to a child should take place in the presence of a parent and/or guardian.					
8153	Oral hygiene instruction - each additional visit	06.03	37.20 (32.60)			B
	Report code 8153 when additional oral hygiene instructions is required as part of the treatment plan. No other preventive services may be reported at the same visit. See code 8151					
8155	Polishing - complete dentition	06.03	62.20 (54.60)			B
	A polishing involves the removal of stains and plaque from the clinical crowns of natural teeth, and making the surface smooth and glossy, to help minimise the loss of enamel and decrease the possibility of damage to restorations. Includes the complete primary, transitional or permanent dentition. This code should not be used concurrent with codes 8159 or 8160. See code 8157 in the restorative section for the re-burnishing and polishing of restorations.					
8159	Prophylaxis - complete dentition	06.03	113.20 (99.30)			B
	A prophylaxis involves a series of procedures whereby calculus, stain, and other accretions are removed from the clinical crowns of teeth. A prophylaxis includes, but is not limited to a scaling and polishing of the complete primary, transitional or permanent dentition. Code 8159 should not be used concurrent with code 8155 or 8160.					
8161	Topical application of fluoride - child	06.03	62.20 (54.60)			B
	To be used for treatment of complete dentition to prevent dental decay. Report code 8167 in the miscellaneous section when fluoride is used as desensitising medicament. Should not be used concurrent with code 8167. A patient is defined as an adult beginning at age 12.					
8162	Topical application of fluoride - adult	06.03	62.20 (54.60)			B
	See code 8161.					
8163	Dental sealant	06.03	46.00 (40.40)	T		B
	Also known as pit-and fissure sealant. This procedure involves the mechanical and/or chemical preparation of an occlusal enamel surface and placement of a material to seal decay-prone pits, fissures, and grooves of a tooth. A preventive resin restoration is distinguished from a sealant in that in a restorative the decay penetrates into dentin. If the caries is limited to the enamel, it is still considered a sealant. Limitation: Certain funders limit benefits for sealants to two teeth per quadrant.					
	Note : 8163 chargeable once only in respect of a tooth per annum. 8163 apply to individuals below 21 years of age. Fee for patients over 21 years of age by arrangement with scheme.	06.03				

Code	Description	Ver	Dental Therapy	M P	Lab	T C
Extractions during a single visit.						
8201	Extraction - tooth or exposed tooth roots (first per quadrant)	06.03	72.50 (63.60)	T		B
	The removal of an erupted tooth or exposed tooth roots by means of elevators and/or forceps. This includes the routine removal of tooth structure and suturing when necessary. Report per tooth. The removal of more than one exposed root of the same tooth should be reported as one extraction. When a normal extraction fails and residual tooth roots are surgically removed during the same visit, code 8937 should be reported.					
8202	Extraction - each additional tooth or exposed tooth roots	06.03	28.00 (24.60)	T		B
	To be reported for an additional extraction in the same quadrant at the same visit.					
8145	Local anaesthetic - per visit	06.03	11.00 (9.65)			B
	Use for infiltrative anaesthesia (anaesthetic agent is infiltrated directly into the surgical site by means of an injection). Excludes topical anaesthesia (anaesthetic agent is applied topically to the mucosa/skin). Report per visit. Comment: The fee for topical anaesthesia are considered to be part of, and included in the fee for the local anaesthesia (injection). Code 8145 includes the use of the Wand.					
8220	Cost of suture material	06.03	-			B
	Comment: Use in conjunction with procedure(s) when suture material is provided by the practitioner. Report per pack. See Rule 002 and Modifier 8025 for direct material costs.					
8931	Treatment of post-extraction haemorrhage	06.03	47.30 (41.50)			S
	Involves the treatment of local haemorrhage following extraction. Report per visit. Excludes treatment of bleeding in the case of blood dyscrasias (8933), e.g. haemophilia. Routine post operative visits for irrigation, dressing change and suture removal are considered to be part of, and included in the fee for the surgical service.					
8935	Treatment of septic socket	06.03	47.30 (41.50)			S
	Involves the treatment of localised inflammation of the tooth socket following extraction due to infection or loss of blood clot; osteitis. Report per visit. Routine postoperative visits for irrigation, dressing change and suture removal are considered to be part of, and included in the fee for, the surgical service.					
9011	Incision & drainage of abscess - intra-oral (pyogenic)	05.02	89.30 (78.30)	M		S
8303	Pulp cap - indirect	06.03	91.90 (80.60)	T		B
	This procedure involves the covering of the nearly exposed pulp with a protective material to protect it from external irritants and to promote healing. Excludes the final restoration.					
Amalgam restorations (including polishing).						
8341	Amalgam - one surface	04.00	132.70 (116.40)	T		B
8342	Amalgam - two surfaces	04.00	163.60 (143.50)	T		B
8343	Amalgam - three surfaces	04.00	199.40 (174.90)	T		B
8344	Amalgam - four or more surfaces	04.00	222.10 (194.80)	T		B
	Only one of the above items may be charged per tooth within a year.	06.03				
Resin restorations (using resin bonding technique)						
8351	Resin - one surface, anterior	04.00	160.50 (140.80)	T		B
8352	Resin - two surfaces, anterior	04.00	201.80 (177.00)	T		B
8367	Resin - one surface, posterior	06.03	174.00 (152.60)	T		B
	This is not a preventative procedure and should only be used to restore a carious lesion or a deeply eroded area into a natural tooth. See also code 8163 - sealant.					
8369	Resin - three surfaces, posterior	04.00	260.00 (228.10)	T		B
8370	Resin - four or more surfaces, posterior	04.00	279.70 (245.40)	T		B
8368	Resin - two surfaces, posterior	04.00	215.30 (188.90)	T		B
8353	Resin - three surfaces, anterior	04.00	241.10 (211.50)	T		B
8354	Resin - four or more surfaces, anterior	06.03	269.10 (236.10)	T		B
	Use to report the involvement of four or more surfaces or the incisal line angle. The Incisal line angle is the junction of the incisal and the mesial or distal surface of an anterior tooth.					
8350	Resin crown - anterior primary tooth (direct)	06.03	289.30 (253.80)	T		B

Code	Description	Ver	Dental Therapy	MP	Lab	TC
	This procedure involves the full coverage of an anterior primary tooth with a resin based material.					
	Note: Only one of the above codes may be charged per tooth within a year.	06.03				
Palliative Treatment						
8131	Emergency dental treatment	06.03	64.70 (56.80)	T		B
	This code is intended to be used for emergency treatment to alleviate dental pain but is not curative - report per visit. This code should not be used when more adequately described procedures exists and may not be reported with other procedure codes (diagnostic procedures and professional visits excluded).					
8165	Sedative filling	06.03	64.70 (56.80)	T	+L	B
	The intention of this code is to report a temporary restoration to relieve pain. It should not be used as a temporary restoration in conjunction with root canal therapy, a base or liner under a restoration. Use this code to report a ZOE restoration or ART technique. May not be reported with other procedure codes on the same visit for a tooth.					
8166	Application of desensitising resin, per tooth	06.03	42.70 (37.50)	T		B
	This procedure involves the application of adhesive resins on a cervical and/or root surface and should not to be used for bases, liners, or adhesives under restorations - report per tooth.					
8167	Application of desensitising medicament, per visit	06.03	49.80 (43.70)			B
	This procedure involves the application of topical fluoride on teeth and/or root surfaces and should not to be used for bases, liners, or adhesives under restorations - report per visit (irrespective of number of teeth treated). The intention of this code is to treat persistent pain and not to prevent decay. Fluoride application is considered treatment for caries control – See codes 8161 and 8162. Comment: This code should not be reported together with codes 8161 and 8162.					

DIETICIANS

Dieticians 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY DIETICIANS 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

003	Dietary services are per individual patient.	04.00
004	Each practitioner must acquaint him-/herself with the provisions of the Medical Schemes Act, as amended, and the regulations promulgated under the Act and shall render a monthly account in respect of any service rendered during the month, irrespective of whether or not the treatment has been completed. NB. Every account shall contain the following particulars · 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 nature of the treatment. · The date on which the service was rendered. · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.	04.00
005	When multiple diagnoses apply every applicable diagnosis shall be specified on the statement.	04.00
010	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
011	Compilation of reports is only to be included within billable time if these reports are for purposes of motivating for therapy and/or giving a progress report and/or a pre-authorisation report, and where such a report is specifically required by the medical scheme. Maximum billable time for such a report is 15 minutes.	05.03

MODIFIERS

0021	Services to hospital inpatients: Quote modifier 0021 on all accounts for services performed on hospital inpatients.	04.00

ITEMS

1. INDIVIDUAL ASSESSMENT, COUNSELLING AND/OR TREATMENT

Code	Description	Ver	Add	Dietetics RVU	Dietetics Fee
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			
200	Nutritional assessment, counselling and/or treatment. Duration: 1-10min.	05.03		0.500	26.30 (23.10)
201	Nutritional assessment, counselling and/or treatment. Duration: 11-20min.	05.03		1.500	78.80 (69.10)
202	Nutritional assessment, counselling and/or treatment. Duration: 21-30min.	05.03		2.500	131.40 (115.30)
203	Nutritional assessment, counselling and/or treatment. Duration: 31-40min.	05.03		3.500	183.90 (161.30)
204	Nutritional assessment, counselling and/or treatment. Duration: 41-50min.	05.03		4.500	236.40 (207.40)
205	Nutritional assessment, counselling and/or treatment. Duration: 51-60min.	05.03		5.500	289.00 (253.50)
206	Nutritional assessment, counselling and/or treatment. Duration: 61-70min.	05.03		6.500	341.50 (299.60)
207	Nutritional assessment, counselling and/or treatment. Duration: 71-80min.	05.03		7.500	394.10 (345.70)
208	Nutritional assessment, counselling and/or treatment. Duration: 81-90min.	05.03		8.500	446.60 (391.80)
209	Nutritional assessment, counselling and/or treatment. Duration: 91-100min.	05.03		9.500	499.10 (437.80)
210	Nutritional assessment, counselling and/or treatment. Duration: 101-110min.	05.03		10.500	551.70 (483.90)
211	Nutritional assessment, counselling and/or treatment. Duration: 111-120min.	05.03		11.500	604.20 (530.00)

2. GROUP ASSESSMENT, COUNSELLING AND/OR TREATMENT

	Group nutritional assessment, counselling and/or treatment items are chargeable to a maximum of 12 patients.				05.03
300	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 1-10min.	05.03		0.100	5.25 (4.61)
301	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 11-20min.	05.03		0.300	15.80 (13.90)
302	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 21-30min.	05.03		0.500	26.30 (23.10)

Code	Description	Ver	Add	Dietetics	
				RVU	Fee
303	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 31-40min.	05.03		0.700	36.80 (32.30)
304	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 41-50min.	05.03		0.900	47.30 (41.50)
305	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 51-60min.	05.03		1.100	57.80 (50.70)
306	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 61-70min.	05.03		1.300	68.30 (59.90)
307	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 71-80min.	05.03		1.500	78.80 (69.10)
308	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 81-90min.	05.03		1.700	89.30 (78.30)
309	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 91-100min.	05.03		1.900	99.80 (87.50)
310	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 101-110min.	05.03		2.100	110.30 (96.80)
311	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 111-120min.	05.03		2.300	120.80 (106.00)

HEARING AID ACOUSTICIANS

Hearing Aid Acousticians 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY HEARING AID ACOUSTICIANS 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

003	The fee in respect of more than one evaluation shall be the full fee for the first evaluation plus half the fee in respect of each additional evaluation, but under no circumstances may fees be charged for more than three evaluations carried out.	04.00
004	Each practitioner shall render a monthly account in respect of any service rendered during the month, irrespective of whether or not the treatment has been completed. NB. Every account shall contain the following particulars : · The practice code number of the supplier of service · The name of the collaborating medical practitioner or audiologist. · The name of the member. · The name of the patient. · The name of the medical scheme. · The membership number of the member. · The nature of the treatment. · The date on which the service was rendered. · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.	04.00
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

ITEMS

Code	Description	Ver	Add	Hearing Aid Acousticians	
				RVU	Fee
001	First consultation (comprehensive)	04.00		15.700	81.40 (71.40)
003	Consultation (screening interview)	04.00		10.000	51.90 (45.50)
021	Test - air conduction	04.00		10.000	51.90 (45.50)
023	Test - bone conduction	04.00		10.000	51.90 (45.50)
025	Test - speech hearing tests	04.00		14.000	72.60 (63.70)
027	Test - free field	04.00		12.800	66.40 (58.20)
029	Test - insertion gain (per ear)	04.00		10.900	56.50 (49.60)
031	Test - binaural loudness balance test, per ear	04.00		12.800	66.40 (58.20)
051	Global charge for supply and fitting of hearing aid and follow-up (By arrangement with scheme)	04.00		-	-
053	Hearing Aid Evaluation, per ear (refer to General Rule 003)	04.00		12.800	66.40 (58.20)
055	Technical adjustment or replacement of earmolds	04.00		21.100	109.40 (96.00)
057	Repairs/service per instrument (3 X services/4 year cycle)	04.00		-	-
059	Tympanogram	04.00		10.000	51.90 (45.50)
061	Reflex test (stapedial reflex)	04.00		10.000	51.90 (45.50)
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		-	-

HOMOEOPATHS

Homoeopaths 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY HOMOEOPATHS 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		
1	All accounts must be presented with the following information clearly stated: · name of homoeopath; · qualifications of the homoeopath; · 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 nature of treatment; · the surname and initials of the member; · the first name of the patient; · the name of the scheme; · the membership number of the member; · where the account is a photocopy of the original, certification by way of a rubberstamp or the signature of the homoeopath; and · a statement of whether the account is in accordance with the National Reference Price List.	04.00
2	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
Definition: Consultations		
	Consultation: A situation where a Homoeopathic Practitioner takes down a patient's full history and (where applicable) performs an appropriate examination, and repertorisation of the case and study of Materia Medica and/or prescribes or administers treatment and/or medicine or assists the patient with advice. (The method of repertorisation and selection of medicine is determined by the practitioner). or A voluntary scheduled consultation for the same condition within four (4) months (although the symptoms may differ from those presented during the first consultation). It may imply taking down a history and/or repertorisation of the case and study of Materia Medica and/or examination and/or prescribing or administering of treatment and/or medicine and/or counselling. Multiple complaints attended to during same visit: Only one consultation fee is chargeable although the patient may present with a number of complaints. If the patient has an unrelated complaint at the time of administering e.g. a homoeopathic injection as part of a course only a fee for a visit is appropriate. Hospital visits: at hospital or nursing home (all hours). By arrangement with scheme/patient.	06.04
Definition: Medicines		
	Prescribed medicine: Homoeopathic medicines are prescribed in accordance with the homoeopathic principles and philosophy. The philosophy may consist of a classical, a clinical or a combined classical/clinical approach. The prescription may include proprietary homoeopathic medicine, or patient specific compounded medicine or a combination of both. The prescription may also include specially imported medicine. The medicine may be prescribed in the form of a tablet, capsules, ampoules, liquid drops, liquid syrup, eardrops, nose drops, eye drops, pillules, granules, powders, ointments, creams, suppositories, stickers, etc. The medicine may be prescribed in a simplex potency, mother tincture (Æ), low potency, multi-potency, etc and/or complex form. Proprietary medicine: These are registered medicines (consonant with the homoeopathic scope of practice) that are available in the open market or trade, or which are bought in bulk from manufacturers or wholesalers and dispensed to patients in smaller volumes without any compounding or manipulation. The dispensing of such medicine requires the appropriate NAPPI Code provided by the Manufacturer/Distributor. Non-proprietary homoeopathic medicine: These are homoeopathic medicines (consonant with the homoeopathic scope of practice) which are formulated and/or prepared and/or manipulated, and/or compounded in-house by the registered homoeopathic practitioner, and/or by a registered homoeopathic medicine manufacturer in accordance with the prescription and/or formula of the registered homoeopathic practitioner and which is not available in the market/trade. Dispense/Dispensing: in terms of Act 101 of 1965 means in the case of a medical practitioner, dentist, practitioner, nurse or any prescriber authorised to dispense medicines. i. the interpretation and evaluation of a prescription; ii. the selection, reconstitution, dilution, labelling, recording and supply of the medicine in an appropriate container; or iii. the provision of information and instructions to ensure safe and effective use of a medicine by a patient. Compound/Compounding: means to prepare, mix, combine, package and label a medicine for dispensing as a result of a prescription for an individual patient by a pharmacist or a person authorised in terms of Act 101 of 1965. Proprietary Materials: To be used for all material and/or unregistered/unscheduled products used in treatment. The appropriate NAPPI code(s), where applicable, must be provided.	09.00

Code	Description	Ver	Add	Homoeopathy RVU	Homoeopathy Fee
General Rules on Medicines, supplies, material and use of own equipment in treatment and procedures					
	MEDICINE CODE USAGE: Licensed Practitioners 201: as medicine dispensed to patients may only be used by a practitioner licensed to dispense medicine. 202-204: as compounded medicines which are dispensed to patients may only be used by a practitioner licensed to compound and dispense medicine 221-224: may be used by a licensed practitioner in the administration or usage of a medicine or material during the consultation. Items 222-224 specifically require a compounding license. 209: the use or administration of proprietary materials during a consultation. Unlicensed Practitioners: 221: administered proprietary medicine (consonant with the homoeopathic scope of practice) to patients during the consultation as administration does not warrant a dispensing license as per Regulation 18, Act 101 of 1965, which states: Regulation 18, Act 101 (8) For the purposes of this regulation, "compounding and dispensing" does not refer to a medicine requiring preparation for a once-off administration to a patient during a consultation. 209: the use or administration of proprietary materials during a consultation 400: a dispensing code allowing the dispensing of proprietary Homoeopathic medicine to a patient for an emergency medical condition on a once-off basis by an unlicensed practitioner. This should only be used bearing in mind the understanding of the term "emergency medical condition" where failure to such an act would prove a danger to the patient or community or as defined by the Regulations to the Medical Schemes Act, 1998 (Act 131 of 1998): "Emergency Medical Condition" means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy. Reflection of NAPPI/NHRPL codes on electronic and paper claims: 1. NAPPI Codes are only relevant for Items 201, 221 and, if applicable, 209 2. Due to the nature of non-proprietary medicine, no NAPPI codes exist for items 202-204 and 222-224 and the inclusion of the NHRPL codes should be regarded as sufficient 3. For electronic claims each NHRPL and/or NAPPI code should be reflected on its own line followed by consecutive columns: the Single Exit Price (SEP) or NHRPL value (VAT inclusive) of the specific medicine and the total amount reflecting a VAT inclusive amount.				09.00
	Items 201 and 209 provide for the charge of material and medicine used in treatment. · All materials used should be specified on all accounts. · Medicine, bandages and other essential materials for home-use by the patient must be obtained from a chemist on prescription or, if a chemist is not readily available, the practitioner may supply it from own stock provided a relevant prescription is attached to the account. · Not appropriate for items such as spatulas that are normally used in examinations in the rooms. · Not appropriate for items such as syringes, needles and gloves, etc. · Practitioners are not allowed to sell sphygmomanometers (blood pressure meters) or electro-medical devices to patients. · For side room testing by practitioners no extra charge in terms of item 201 is applicable for material or kits used. The amount charged in respect of proprietary medicines shall be at net acquisition price. In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus - * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.				06.05
ITEMS					
1.	**Consultations**				
Code	**Description**	**Ver**	**Add**	**Homoeopathy RVU**	**Homoeopathy Fee**
301	Consultation (initial or follow up). Duration 5 - 15 mins	09.00		10.000	53.60 (47.00)
302	Consultation (initial or follow up). Duration 16 - 30 mins	06.04		22.500	120.50 (105.70)
303	Consultation (initial or follow up). Duration 31 - 45 mins	06.04		37.500	200.80 (176.10)
304	Consultation (initial or follow up). Duration 46 - 60 mins	06.04		52.500	281.10 (246.60)
004	Consultation, each additional full 15 mins, to a maximum of 60 mins	06.04		15.000	80.30 (70.40)
003	Hospital visit (BY ARRANGEMENT)	04.00		-	-
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		-	-

Code	Description	Ver	Add	Homoeopathy	
				RVU	Fee
2.	**Medicines and Materials**				
2.1	**Licensed practitioner in licensed area:**				
Dispensed Medicine:					
	Codes 201 - 204 are to allow for the dispensing of medicine - either proprietary or non-proprietary. Code 201 requires only a Dispensing License Codes 202 - 204 require a combined Compounding and Dispensing license				09.00
201	Proprietary (dispensed) medicine, all forms related to homoeopathic scope of practice. The amount charged in respect of proprietary homeopathic medicines shall be at cost using appropriate NAPPI code.	09.00		-	-
202	Non-proprietary (compounded and dispensed) Homoeopathic Medicine - Tablets & Capsules (each)	09.00		0.100	1.09 (0.96)
203	Non-proprietary (compounded and dispensed) Homoeopathic Medicine - Liquid drops (per ml)	09.00		0.230	2.52 (2.21)
204	Non-proprietary (compounded and dispensed) Homoeopathic Medicine - Pillules & granules (per ml)	09.00		0.230	2.52 (2.21)
Administered Medicine/Materials:					
221	Proprietary (administered) medicine, all forms related to homoeopathic scope of practice. The amount charged in respect of proprietary homeopathic medicines shall be at cost using appropriate NAPPI code.	09.00			
222	Non-proprietary (compounded and administered) Homoeopathic Medicine - Tablets & Capsules (each)	09.00		0.100	1.09 (0.96)
223	Non-proprietary (compounded and administered) Homoeopathic Medicine - Liquid drops (per ml)	09.00		0.230	2.52 (2.21)
224	Non-proprietary (compounded and administered) Homoeopathic Medicine - Pillules & granules (per ml)	09.00		0.230	2.52 (2.21)
209	Proprietary Materials (administered)	09.00			
2.2	**Unlicensed practitioner OR licensed practitioner in unlicensed area:**				
Dispensed Medicine:					
400	Once off dispensing: Once off dispensing of proprietary homeopathic medicine, all forms, by unlicensed Homoeopathic practitioners or licensed homoeopathic practitioner in an unlicensed area. The amount charged in respect of proprietary homeopathic medicines shall be at cost using appropriate NAPPI code. To be used as emergency only.	09.00		-	-
Administered Medicine:					
221	Proprietary (administered) medicine, all forms related to homoeopathic scope of practice. The amount charged in respect of proprietary homeopathic medicines shall be at cost using appropriate NAPPI code.	09.00			
209	Proprietary Materials (administered)	09.00			

HOSPICES

Hospices 2009

DRAFT NATIONAL REFERENCE PRICE LIST IN RESPECT OF HOSPICE OR SIMILAR APPROVED FACILITIES WITH A PRACTICE NUMBER COMMENCING WITH "79" 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

A	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

SCHEDULE

10 HOSPICE OR SIMILAR APPROVED FACILITIES WITH A PRACTICE NUMBER COMMENCING WITH "79"

Code	Description	Ver	Add	Hospices	
				RVU	Fee
950	Ward fee, per day (Inclusive of professional fees and disposables, except for pharmacy dispensed medication).	05.02		30.552	729.50 (639.90)
955	Home health care, per visit	04.00		10.000	238.80 (209.50)
960	Global fee for a terminally ill patient - By arrangement with medical scheme/patient	05.02		-	-

MEDICAL PRACTITIONERS

Medical Practitioners 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY MEDICAL 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.

RULES GOVERNING THE STRUCTURE

A.	Consultations: Definitions: (a) New and established patients: A consultation/visit refers to a clinical situation where a medical practitioner personally obtains a patient's medical history, performs an appropriate clinical examination and, if indicated, administers treatment, prescribes or assists with advice. These services must be face-to-face with the patient and excludes the time spent doing special investigations which receive additional remuneration. (b) Subsequent visits: Refers to a voluntarily scheduled visit performed within four (4) months after the first visit. It may imply taking down a medical history and/or a clinical examination and/or prescribing or administering of treatment and/or counselling. (c) Hospital visits: Where a procedure or operation was done, hospital visits are regarded as part of the normal after-care and no fees may be levied (unless otherwise indicated). Where no procedure or operation was carried out, fees may be charged for hospital visits according to the appropriate hospital or inpatient follow-up visit code.	04.00
B.	Normal hours and after hours: After-hours services are paid at the same rate as benefits for normal hours services. Bona fide emergency medical services rendered to a patient, at any time, may attract a fee as specified in modifier 0011 and items 0146 or 0147 (which should be added to the appropriate consultative services code selected from items 0190-0192, 0173-0175, 0161-0164, 0166-0169)	06.04
C.	Comparable services: A service may be rendered that is not listed in this edition of the coding structure. The fee that may be charged in respect of the rendering of a service not listed in this coding structure shall be based on the fee in respect of a comparable service. For these procedure(s)/service(s), item 6999: Unlisted procedure or service code, should be used. Please contact the SA Medical Association (SAMA) Private Practice Unit via e-mail on coding@samedical.org to obtain a comparable code for the unlisted procedure/service which will be based on the fee for a comparable service in the coding structure. When item 6999 is used to indicate that an unlisted service was rendered, the use of the item must be supported by a special report. This report must include: (1) An adequate definition or description of the nature, extent and need for the procedure/service or "medical necessity"; (2) In which respect is this service unusual or different in technique, compared to available procedures/services listed in the coding structure? Information regarding the nature and extent of the procedure/service, time and effort, special/dedicated equipment needed to provide this service, must be included in the report; (3) Is this procedure/service medically appropriate under the circumstances? Explain why another procedure/service listed in the coding structure will not be appropriate in this case; (4) A description of the complexity of the symptoms and concurrent problems must be supplied; (5) Final diagnosis supported by the appropriate ICD-10 code(s); (6) Pertinent physical findings (size, location and number of lesions if applicable); (7) Mention any other diagnostic or therapeutic procedure(s)/service(s) provided at the same session; (8) Any further diagnostic or therapeutic procedure(s)/service(s) to be provided in the follow-up period; and (9) Description of the follow-up care needed. Please note: This comparable service code may not be used for a period longer than six months for a particular procedure/service after which time an application has to be made for the addition of a specific code for this procedure	05.02
D.	Cancellation of appointments: Unless timely steps are taken to cancel an appointment for a consultation, the relevant consultation fee may be charged. In the case of a general practitioner "timely" shall mean two hours and in the case of a specialist 24 hours prior to the appointment. Each case shall, however, be considered on merit and, if circumstances warrant, no fee shall be charged. If a patient has not turned up for a procedure, each member of the surgical team is entitled to charge for a visit at or away from doctor's rooms as the case may be	04.00
E.	Pre-operative visits: The appropriate fee may be charged for all pre-operative visits with the exception of a routine pre-operative visit at the hospital	04.00
F.	Administering of injections and/or infusions: Where applicable, fees for administering injections and/or infusions may only be charged when done by the practitioner himself	04.00
G.	Post-operative care: (a) Unless otherwise stated, the fee in respect of an operation or procedure shall include normal after-care for a period not exceeding ONE month (after-care is excluded from pure diagnostic procedures during which no therapeutic procedures were performed). (b) If the normal after-care is delegated to any other registered health professional and not completed by the surgeon, it shall be his/her own responsibility to arrange for this to be done without extra charge. (c) When post-operative care/treatment of a prolonged or specialised nature is required, such fee as may be agreed upon between the surgeon and the scheme or the patient (in case of a private account) may be charged. (d) Normal after-care refers to an uncomplicated post-operative period not requiring any further incisions	04.00
H.	Removal of lesions: Items involving removal of lesions include follow-up treatment for 10 days	04.00
J.	Disproportionately low fees: In exceptional cases where the fee is disproportionately low in relation to the actual services rendered by a medical practitioner, a higher fee may be negotiated. The use of this rule is not intended merely to increase the Medical Schemes Benefits.	04.00
K.	Practice of specialists: In terms of the conditions in respect of the practice of specialists as published in Government Gazette No. 12958 of 11 January 1991, a specialist may treat any person who comes to him direct for consultation. A specialist who is consulted by a patient or who treats a patient, shall take all reasonable steps to ensure the collaboration of the patient's general practitioner. Medical practitioners referring cases to other medical practitioners shall indicate in the reference whether the patient is a member of a medical scheme or a dependant of such member. This also applies in respect of specimens sent to pathologists	04.00
L.	Procedures performed at time of visits: If a procedure is performed at the time of a consultation/visit, the fee for the visit PLUS the fee for the procedure is charged	04.00

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
M.	Procedure planned to be performed later: In cases where, during a consultation/visit, a procedure is planned to be performed at a later occasion, a visit may not be charged for again, at such a later occasion								04.00
N.	"Per consultation": No additional fee may be charged for a service for which the fee is indicated as "per consultation". Such services are regarded as part of the consultation/visit performed at the time the condition is brought to the doctor's attention								04.00
O.	Costly or prolonged medical services or procedures: In the case of costly or prolonged medical services or procedures, the medical practitioner shall first ascertain from the medical scheme for what amount the medical scheme will accept responsibility in respect of such treatment, should the practitioner wish any direct payment from the scheme								04.00
P.	Travelling fees: (a) Where, in cases of emergency, a practitioner was called out from his residence or rooms to a patient's home or the hospital, travelling fees can be charged according to the section on travelling expenses (section IV) if he had to travel more than 16 kilometres in total. (b) If more than one patient would be attended to during the course of a trip, the full travelling expenses must be divided between the relevant patients. (c) A practitioner is not entitled to charge for any travelling expenses or travelling time to his rooms. (d) Where a practitioner's residence would be more than 8 kilometres away from a hospital, no travelling fees may be charged for services rendered at such hospitals, except in cases of emergency (services not voluntarily scheduled). (e) Where a practitioner conducts an itinerant practice, he is not entitled to charge fees for travelling expenses except in cases of emergency (services not voluntarily scheduled). (f) For voluntarily scheduled services, fees for travelling expenses may only be charged where the patient and the practitioner have entered into an agreement to this effect. Medical scheme benefits will not be applicable in such instances.								04.00
Q.	Intensive care/High Care: Units in respect of items 1204 to 1210 (Categories 1 to 3) EXCLUDE the following: (a) Anaesthetic and/or surgical fees for any condition or procedure, as well as a first consultation/visit, which is, regarded as the assessment of the patient, while the daily intensive care/high care fee covers the daily care in the intensive/high care unit. (b) Cost of any drugs and/or materials. (c) Any other cost which may be incurred before, during or after the consultation/visit and/or the therapy. (d) Blood gases and chemistry tests, including the arterial puncture to obtain the specimen. (e) Procedural items 1202 and 1212 to 1221. but INCLUDE the following: (f) Performing and interpretation of a resting ECG. (g) Interpretation of chemistry tests and x-rays. (h) Intravenous treatment (items 0206 and 0207), except intravenous infusion in patients under the age of three years (item 0205) that does not form a part of the daily ICU/High Care fee and may be charged for separately on a daily basis (fee includes the introduction of the cannula as well as the daily management)								06.05
R.	Multiple organ failure: Units for items 1208, 1209 and 1210 (Category 3: Cases with multiple organ failure) include resuscitation (i.e. item 1211: Cardio-respiratory resuscitation)								04.00
S.	Ventilation: Units for items 1212, 1213 and 1214 (ventilation) include the following: (a) Measurement of minute volume, vital capacity, time- and vital capacity studies. (b) Testing and connecting the machine. (c) Putting patient on machine: setting machine, synchronising patient with machine. (d) Instruction to nursing staff. (e) All subsequent visits for 24 hours.								04.00
T.	Ventilation (items 1212 to 1214) does not form a part of normal post-operative care, but may not be added to item 1204: Catogory 1: Cases requiring intensive monitoring								04.00
U.	Obstetric procedures: (a) When a general practitioner treats a patient in the ante-natal period and, after starting the confinement, requests an obstetrician to take over the case, the general practitioner shall be entitled to charge for all the ante-natal consultations he/she has performed. (i) If the patient has been in labour for less than 6 hours, the general practitioner shall charge 50,00 clinical procedure units according to item 2614: Global obstetric care. (ii) If the patient has been in labour for more than 6 hours, the general practitioner shall charge 80,00 clinical procedure units according to item 2614: Global obstetric care. (b) When a general practitioner calls an obstetrician to help with a confinement, take over the management of a confinement, and treats the patient until after the post-partum visit, the obstetrician shall charge according to item 2614: Global obstetric care. (c) When a general practitioner calls an obstetrician (specialist or general practitioner) to help with a confinement, or take over the management of a confinement, but the general practitioner treats the patient until after the post-partum visit, the obstetrician shall charge according to item 2616: Intrapartum obstetric care by obstetrician in consultation, and the general practitioner according to item 2614: Global obstetric care.								04.00
V.	(a) Electro-convulsive treatment: Visits at hospital or nursing home during a course of electro-convulsive treatment are justified and may be charged for in addition to the fees for the procedure. (b) Except where otherwise indicated, the duration of a medical psychotherapeutic session is set at 20 minutes or part thereof, provided that such a part comprises 50% or more of the time of a session. This set duration is also applicable for psychiatric examination methods								04.00
Y.	Except where otherwise indicated, radiologists are entitled to charge for contrast material used								04.00
Z.	No fee is subject to more than one reduction								04.00
AA.	Procedures to exclude cost of isotope								04.00
BB.	The fees in this section (radiation oncology) do NOT include the cost of radium or isotopes								04.00
CC.	Acupuncture: (a) When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately. (b) Not more than two separate techniques may be charged for at each session. (c) The maximum number of acupuncture treatments per course to be charged for is limited to 20. If further treatment is required at the end of this period of treatment, it should be negotiated with the patient. (d) Item 0380 refers to scalp acupuncture as a treatment in its own right and not to the use of acupuncture points on the scalp								04.00

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
EE.	Ultrasound examinations: The international norm approved for use in South Africa for NORMAL PREGNANCY is two ultrasound exams: (a) The first scan should preferably include a nuchal thickness estimation and be performed between 10 and 14 weeks gestation. The second scan should be performed between 20 and 24 weeks and should include a full anatomical report. All subsequent ultrasound scans are excluded from the benefits of medical schemes unless accompanied by proper motivation. An ultrasound scan to assess an abnormal early pregnancy may be formed before 10 weeks but this scan may not be used to diagnose a normal uncomplicated pregnancy. Item 3618 is a gynaecological scan and its use is not approved for use in pregnancy. (b) In cases where the scan is performed by the attending practitioner, a clear indication for such a scan must be entered on the account rendered, or a letter of motivation must be attached to the account (the practitioner must elect one of the two options). (c) In case of a referral, the referring doctor must submit a letter of motivation to the radiologist or other practitioner doing the scan. A copy of the letter of motivation must be attached to the first account rendered to the patient (by the radiologist or the other practitioner doing the scan) and must be attached to the first account submitted to the medical scheme by the patient or the doctor, as the case may be. (d) In case of a referral to a radiologist, no motivation should be required from the radiologist								04.00
FF.	(a) When a cystoscopy precedes a related operation, Modifier 0013: Endoscopic examination done at an operation, applies, e.g. cystoscopy followed by transurethral (TUR) prostatectomy. (b) When a cystoscopy precedes an unrelated operation, Modifier 0005: Multiple procedures/operations under the same anaesthetic, applies, e.g. cystoscopy for urinary tract infection followed by inguinal hernia repair. (c) No modifier applies to item 1949: Cystoscopy, when performed together with any of items 1951 to 1973.								04.00
GG.	Capturing and recording of examinations: Images from all radiological, ultrasound and magnetic resonance imaging procedures must be captured during every examination and a permanent record generated by means of film, paper, or magnetic media. A report of the examination, including the findings and diagnostic comment, must be written and stored for five years								04.00
RR.	The radiology section in this price list is not for use by registered specialist radiology practices (Pr No "038") or nuclear medicine practices (Pr No "025"), but only for use by other specialist practices or general practitioners. A separate radiology schedule is for the exclusive use of registered specialist radiology practices (Pr No "038") and nuclear medicine practices (Pr No "025").								04.00
XX.	Diagnostic services rendered to hospital inpatients: Quote Modifier 0091 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients officially admitted to hospital or day clinic								04.00
YY.	Diagnostic services rendered to outpatients: Quote Modifier 0092 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients NOT officially admitted to hospital or day clinic (could be within the confines of a hospital)								04.00
MODIFIERS GOVERNING THE STRUCTURE									
0002	Written report on X-rays: The lowest level code for a new patient office (consulting rooms) visit, is applicable only where a radiologist is requested to give a written report on X-rays taken elsewhere and submitted to him. The above mentioned item and the lowest level initial hospital visit code, as appropriate are not to be used for routine reporting of X-rays taken elsewhere								04.00
0004	Procedures performed in own procedure rooms: Procedures performed in doctors' own procedure rooms instead of in a hospital theatre or unattached theatre unit: as per fee for procedure + 100% (the value of modifier 0004 equals 100% of the value of the procedure performed). See Section V (Section G in SAMA's DBT) for a list of procedures, which are often done in rooms to which Modifier 0004 should not be applied. Please note: Only the medical practitioner who owns the facility and the equipment may charge modifier 0004. Only one person may claim this modifier for procedures performed in doctors' own procedure rooms								06.05
0005	Multiple therapeutic procedures/operations under the same anaesthetic: a) Unless otherwise identified in the tariff when multiple therapeutic procedures/operations add significant time and/or complexity, and when each procedure/operation is clearly identified and defined, the following values shall prevail: 100% (full value) for the first or major procedure/operation, 75% for the second procedure/operation, 50% for the third procedure/operation, 25% for the fourth and subsequent procedures/operations. This modifier does not apply to purely diagnostic procedures. b) In the case of multiple fractures and/or dislocations the above values shall prevail. c) When purely diagnostic endoscopic procedures or diagnostic endoscopic procedures unrelated to any therapeutic procedures performed, are performed under the same general anaesthetic, Modifier 0005 is not applicable to the fees for such diagnostic endoscopic procedures as the fees for endoscopic procedures do not provide for after-care. Specify unrelated endoscopic procedure and provide diagnosis to indicate diagnostic endoscopic procedure(s) unrelated to other (therapeutic) procedures performed under the same anaesthetic. d) Please note: When more than one small procedure is performed and the tariff makes provision for items for "subsequent" or "maximum for multiple additional procedures" (see Section 2. Integumentary System) Modifier 0005 is not applicable as the fee is already a reduced fee. e) "+" Means that this item is used in addition to another definitive procedure and is therefore not subject to reduction according to Modifier 0005 (see also Modifier 0082)								04.00
0006	Visiting specialists performing procedures: Where specialists visit smaller centres to perform procedures, fees for these particular procedures are exclusive of after-care. The referring practitioner will then be entitled to subsequent hospital visits for after-care. If the referring practitioner is not available, the specialist shall, on consultation with the patient, choose an appropriate locum tenens. Both the surgeon and the practitioner who handled the after-care, must in such instances quote Modifier 0006 with the particular items which they use								04.00