



SASA
SOUTH AFRICAN SOCIETY OF ANAESTHESIOLOGISTS

Private Practice & Coding Guidelines

2018



PRIVATE PRACTICE AND CODING GUIDELINES 2018

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SOUTH AFRICAN SOCIETY OF ANAESTHESIOLOGISTS (SASA)

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1. INTRODUCTION

- 1.1. These guidelines are intended to be used as an aid to ethical billing and coding practice. As such the guidelines are intended to guide SASA members to act in a fair and transparent manner towards all stakeholders whilst always acting in the patient's best interest, both clinically and financially
- 1.2. In the process of compiling the guidelines the Society takes various factors into account which include fairness towards patients and members, transparency, as well as the principles of ethical practice.
- 1.3. These guidelines replace all previous SASA Coding Guidelines and Coding Manuals.
- 1.4. The source documents for the guidelines as at March 2018 are:
 - 1.4.1. The South African Medical Association Medical Doctors' Coding Manual (eMDCM). Members are strongly encouraged to cross reference the guidelines with the eMDCM. Some of the codes and their interpretation may differ from the interpretation in the Medical Doctors Coding Manual. Wherever possible, these instances are marked by an asterisk at the end of the interpretation. Where this situation occurs, it is because the members of the Society's Private Practice Business Unit decided by consensus that the different interpretation is fair and in the interest of our patients and members.
 - 1.4.2. The South African Society of Anaesthesiologists Coding Guideline 2015
 - 1.4.3. The South African Society of Anaesthesiologists Position Statement on Ethical Coding and Billing Practice 2015
 - 1.4.4. Health Professions Council of South Africa: Booklet 2 - General ethical rules
 - 1.4.5. Health Professions Council of South Africa: Booklet 11 - Guidelines on Over servicing, perverse incentives and related matters
 - 1.4.6. Health Professions Council of South Africa: 2016 Directive regarding standard fees for professional services
 - 1.4.7. Health Professions Council of South Africa: 2017 Directive regarding Global Fee Initiatives
 - 1.4.8. Consumer Protection Act no.68/2008: Chapter 2 - Fundamental consumer rights
 - 1.4.9. Medical Schemes Act no. 131/1989
 - 1.4.10. Medical Schemes Amendment Act no 62/2002: Section 59
- 1.5. Section 2 to 7 deals with the ethical communication and contracting with patients/guarantors.
- 1.6. Section 8 to 28 deals with ethical coding practice and is intended to guide members in the appropriate, reasonable and the ethical use of codes when providing an invoice for their services to patients. If the Society receives a billing related complaint, the billing practice would utilise this guideline as the basic source document for evaluation thereof. The responsibility for correct and ethical coding rests exclusively with the individual practitioner delivering the service.
- 1.7. Where there are significant changes in the Guidelines compared to previous versions it is indicated by 
- 1.8. New sections, guidelines or interpretations are indicated by 

2. COMMUNICATION WITH PATIENTS/GUARDIANS/GUARANTORS

- 2.1. Members are encouraged to make a reasonable effort to communicate with the patient/guardian/guarantor at least 24 hours before the planned elective procedure. Communication may take the form of an information leaflet at the surgeons' room, phone call, text message, or Email. It is recommended that members set up an informative website to which patients may be referred via an SMS or Email link.
- 2.2. The patient/guardian/guarantor should be supplied with general information regarding anaesthesia (See Annexure 1), Informed Consent for Anaesthesia (See Annexure 1), a contractual agreement with the Anaesthesiologist (See Annexure 2), and the practice Billing Policy (See Annexure 3).
- 2.3. It is recommended that the patient/guardian/guarantor have an opportunity to request a cost estimate for the planned procedure (See Annexure 3).
- 2.4. The patient/guardian/guarantor must have the opportunity to discuss the costs involved with the member/the member's delegate before a service is rendered.



3. INFORMED CONSENT FOR ANAESTHESIA

- 3.1. Informed consent for anaesthesia must be obtained from the patient and/or guardian in all cases where an anaesthetic service is delivered (See Annexure 1).
- 3.2. The informed consent is only valid for the specific procedure for which the consent was intended.
- 3.3. The informed consent may be withdrawn at any time prior to the commencement of the anaesthesia.
- 3.4. The informed consent must list all risks and complications generally accepted to be part of anaesthesia care. Specific reference is made to booklet 4 of the Health Professions Council of South Africa – Informed Consent.
- 3.5. Members must discuss concerns, risks and complications that may be applicable to the specific procedure or patient before the procedure.



4. CONTRACTUAL PRINCIPLES

- 4.1. The South African Society of Anaesthesiologists (Hereafter referred to as “the Society”) regards the only legally binding contract for the payment of professional fees as that which exists between the service provider and the patient/guardian to which the service is delivered.
- 4.2. This contract supersedes any other contractual relationship the service provider and/or the patient/guardian may have with any third party, including a medical funder.
- 4.3. The patient/guardian remains responsible for the payment of all professional fees that may be charged for the delivery of professional services by the member.
- 4.4. Regarding contractual agreements with third parties:
 - 4.4.1. The Society supports contractual agreements between members and third-party funders if recognised by the Council for Medical Schemes as a bona fide Medical Scheme.
 - 4.4.2. The decision to enter into such a contractual agreement rests exclusively with the individual SASA member and should be informed by, among other considerations, the financial sustainability for the SASA member’s particular practice and the ability to ensure ethical clinical practice in accordance with the guidelines and regulations of the Health Professions Council of South Africa.
- 4.5. The Society regards the following business practices as unethical and will not provide support to members who enter into such arrangements:
 - 4.5.1. A contractual agreement that entices and/or forces and/or coerces the member to act unethically and/or unlawfully and/or in contravention of the patient’s best interest.
 - 4.5.2. A contractual agreement that requires the use of any system of coding and/or reimbursement that is not recognised by the Society.
 - 4.5.3. A contractual agreement that forces a member to make use of or avoid the use of certain drugs and/ or methods and/or equipment and/or facilities that may be to the detriment of the patient.
 - 4.5.4. A contractual agreement that is between a medical practitioner of another discipline and the member.
 - 4.5.5. A contractual agreement that is with a third party which acts on behalf of a funder/s or patient and who derives financial gain from the member delivering a professional service to the patient.
 - 4.5.6. A formal or informal contractual agreement of employment with a specific hospital or hospital group for the rendering of professional services.
 - 4.5.7. A member who owns a business interest in a hospital/hospital group and acts in the financial interest of the said hospital/hospital group in preference to the best interest of the patient.



5. DETERMINATION OF PROFESSIONAL FEES

- 5.1. A standard tariff should be billed for each type of service rendered to all patients according to the coding rules as described in this document.
- 5.2. Every member/ partnership should determine the standard tariff individually, based on objective economic, clinical, and professional criteria.

- 5.3. It remains the prerogative of the individual practitioner to grant an appropriate discount to individual patients on merit or practical commercial factors.
- 5.4. The quality of care/service may not be increased/decreased according to the level of fees charged or discounts offered.

6. CONTRACTUAL AGREEMENT WITH THE ANAESTHESIOLOGIST

- 6.1. Members should use a standardised contract form stating the following at minimum (See Annexure 2):
- 6.1.1. The patient/guarantor remains responsible for payment of the account
 - 6.1.2. All information supplied by the signatories are correct and true, to the knowledge of the signatories
 - 6.1.3. A statement confirming that the signatories have read and understood the terms of the contract and the practice billing policy (if applicable).
 - 6.1.4. full name and surname of person responsible for payment
 - 6.1.5. Signature of person responsible for payment
 - 6.1.6. Date of contract conclusion
 - 6.1.7. Place of contract conclusion
 - 6.1.8. Initial, surname and signature of the individual member delivering the service

7. BILLING POLICY

- 7.1. Every member/practice should have a formal billing policy which must be made available to the patient/guarantor on request. (See Annexure 3)
- 7.2. The billing policy must contain at a minimum (See Annexure 3):
- 7.2.1. A statement declaring which coding authority is used in determining coding
 - 7.2.2. An explanation of the method in which professional tariffs are determined by the practice
 - 7.2.3. An indication of the standard tariff of the practice and a comparison with the tariff offered by major funders
 - 7.2.4. A statement that the final responsibility of administering the account rests with the guarantor
 - 7.2.5. A list of any funders or entities where the practice will not handle the administration on behalf of the guarantor
 - 7.2.6. A statement that Medical Funders may not pay for certain codes/procedures/equipment and a list of the most common examples of these. It must be clearly stated that the guarantor will be responsible for these costs

8. CODING PRINCIPLES

- 8.1. Services involving administration of anaesthesia are reported using the method as described in the South African Medical Association Medical Doctors Coding Manual (latest edition).
- 8.2. When the anaesthetist, other than the medical practitioner performing the procedure, provides anaesthesia services as specified in these guidelines (conscious sedation or otherwise), the anaesthesia codes should be reported.
- 8.3. Standard anaesthesia services may include but are not limited to general, regional, supplementation of local anaesthesia, or other supportive services to afford the patient the anaesthesia care deemed optimal by the anaesthesiologist during any procedure. Monitored anaesthesia care is included in the service and the reporting of any professional anaesthesia services is reported as if a general anaesthetic was administered.



- 8.4. Standard anaesthesia services include the anaesthesia care during the procedure, the administration of fluids and/or blood, usual monitoring services (e.g. ECG, temperature, blood pressure, pulse oximetry, regional oxygen saturation and capnography) and usual procedures necessary to provide safe anaesthetic care (Airway management, peripheral venous access, nasogastric or orogastric intubation if necessary for the anaesthetic care). Central venous and Swan-Ganz insertion, intra-arterial cannulation, nerve blocks, use of ultrasound, nasogastric or orogastric intubation if required to aid the surgical procedure, and specialised techniques of airway management like fibre-optic intubation, bronchoscopy, and one-lung ventilation are not regarded as standard anaesthesia services.

- 8.5. These standard anaesthesia services are reflected in one component of the Base Unit Value, with the other component made up according to the complexity of the procedure being performed.
- 8.6. Time units are added according to the actual time spent providing the anaesthesia service.
- 8.7. Modifying units are added according to several technical factors which may complicate the anaesthesia and/ or require the application of increased levels of expertise or care.
- 8.8. A consultation component for evaluation and/or management of the patient is added.
- 8.9. Non-standard procedures performed by the anaesthetist during the peri-operative period, are reflected in the procedure units and /or ultrasound units.
- 8.10. The use of special equipment, if owned by the practitioner, is not included in the base unit, and billed in addition.
- 8.11. If it is necessary to provide additional support postoperatively in a high care or intensive care setting, ICU codes should be added according to the specific circumstances.
- 8.12. The Rand Conversion Factor (RCF) is the monetary value by which the unit value of a code is multiplied to determine the cost. Each practitioner must determine his/her own value for the RCFs according to objective economic and professional criteria.

9. REPORTING OF ANAESTHESIA SERVICES

- 9.1. All anaesthesia values are determined by adding a Base Unit Value (only one Base Unit Value can be used), which is related to the complexity of the service, plus Procedure Modifiers (codes 0026, 0037-0044), plus Orthopaedic Modifiers (codes 5441-5448), plus Physical Status Modifiers ASA3 – ASA5 (codes 5433-5435). To this is added the Time Units (code 0023).
- 9.2. Basic value or base unit: the basic value also referred to as the base unit or relative value is listed for anaesthetic management of most surgical procedures (Refer to the eMDCM for specific base unit values per procedure). This includes the value of all usual anaesthesia services except for the time spent in anaesthesia care plus any modifiers.
- 9.3. The Anaesthetic fee must be calculated by means of a conversion factor (RCF) since the fee is not based on fixed amounts. The conversion factor is the Rand value associated with each unit of a code.
- 9.4. There are four separate Rand Conversion Factors: one for anaesthetic units, one for consultation units, one for clinical units and one for ultrasound units, each with its own value.
- 9.5. The total fee for the procedure = (Consultation Units multiplied by RCF1) + (Anaesthetic Units multiplied by RCF2) + (Clinical Units multiplied by RCF3) + (Ultrasound Units multiplied by RCF4) where, the Anaesthetic Units = Basic Unit Value + Time Units + Modifying Units. See example below.

<p>NOTE: the RCF values quoted are for illustrative purposes only and actual values will vary according to the billing policy of the anaesthesiologist</p>

CLASSIFICATION	DESCRIPTION	CODE	UNIT	CALCULATION	SUM
CONSULTATION	Pre-operative Risk Assessment	0151	16	16 X R66,00 (RCF1)	R1056,0
ANAESTHETIC UNITS	Fracture: Radius or Ulna	0391	3	3 X R290,00 (RCF2)	R870,00
	Musculoskeletal Modifier	5441	1	1 X R290,00 (RCF2)	R290,00
	Anaesthetic Time X 49 minutes	0023	8	8 X R290,00 (RCF2)	R2320,0
CLINICAL UNITS	Peripheral Nerve Block	2802	25	25 X R38,00 (RCF3)	R950,00
ULTRASOUND UNITS	Ultrasound Soft Tissue	5103	50	50 X R36,00 (RCF4)	R1800,0
TOTAL FEE					R7286,0

9.6. Where additional consultations or procedures are performed on a patient after the anaesthesia is completed, these are coded for on the same account if within the same calendar day as the primary anaesthetic, or a second account is sent if these procedures and consultations take place on subsequent calendar days.

9.7. **0035** – Modifier to be added to an anaesthetic account where the total unit value (basic units plus time units plus appropriate modifiers) for the anaesthetic is less than 7 units. In other words, no anaesthetic will have a value of less than 7 units. See example below.

CLASSIFICATION	DESCRIPTION	CODE	UNITS
CONSULTATION UNITS	Pre-operative Risk Assessment	0151	16
ANAESTHETIC UNITS	Cystoscopy	1951	3
	Minimum Value Anaesthetic Units	0035	2
	Anaesthetic Time X 15 minutes	0023	2

10. BASIC UNIT VALUE

10.1. Only one basic anaesthesia unit code may be coded for per anaesthetic. Where more than one procedure is performed under the same anaesthetic, the basic anaesthetic units will be that of the procedure with the highest number of units (modifier **0027**).

10.2. The basic value units have two components:

10.2.1. The first component reflects all usual services included in the anaesthesia service. Usual services include: administration of fluids and/or blood products incident to the procedure and interpretation of non-invasive monitoring (ECG, temperature, blood pressure, oximetry, and capnography).

10.2.2. The second component reflects the relative work or cost of the specific anaesthesia service. Cost in this context refers to the medical practitioner's expertise/training/risk.

10.2.3. For example, the basic value for the anaesthesia service related to a closed reduction of a radius fracture might be 3,00 anaesthetic units, as it has an average requirement in terms of expertise, training, or risk. The basic value for an anaesthesia service associated with an intrathoracic coronary artery bypass graft procedure will be 15,00 anaesthetic units, reflecting the high level of risk, training or expertise required.

10.3. Four exceptions to using the basic value are listed:

10.3.1. **0034** - A minimum basic value of 5 Anaesthetic units are allowed for all procedures of the **head, neck or shoulder girdle**, requiring field avoidance. See example below.

CLASSIFICATION	DESCRIPTION	CODE	UNITS
CONSULTATION UNITS	Pre-operative Risk Assessment	0151	16
ANAESTHETIC UNITS	Gastroscopy	1587	4
	Head, Neck and Shoulder Girdle Procedure	0034	1
	Anaesthetic Time X 20 minutes	0023	4

10.3.2. **0032** - Any procedure performed in any **position other than lithotomy or supine** has a minimum basic value of 5 anaesthetic units. See example below.

CLASSIFICATION	DESCRIPTION	CODE	UNITS
CONSULTATION UNITS	Pre-operative Risk Assessment	0151	16
ANAESTHETIC UNITS	Colonoscopy	1656	4
	Position other than Supine or Lithotomy	0032	1
	Anaesthetic Time X 25 minutes	0023	4

10.3.3. **1807** - A **laparoscopic / endoscopic procedure** will have a minimum basic value of 5 anaesthetic units. Note that only the code 1807 is included in the account. See example below.

CLASSIFICATION	DESCRIPTION	CODE	UNITS
CONSULTATION UNITS	Pre-operative Risk Assessment	0151	16
ANAESTHETIC UNITS	Appendicectomy	1675	0
	Laparoscopic Procedure	1807	5
	Anaesthetic Time X 31 minutes	0023	6

10.3.4. **0040** - The basic anaesthetic units for procedures performed for **pheochromocytoma** shall have a minimum value of 15,00 anaesthetic units. See example below.

CLASSIFICATION	DESCRIPTION	CODE	UNITS
CONSULTATION UNITS	Pre-operative Risk Assessment	0151	16
ANAESTHETIC UNITS	Adrenalectomy (Unilateral)	2995	9
	Pheochromocytoma	0040	6
	Anaesthetic Time X 260 minutes	0023	50

10.3.5. If the basic unit value associated with the surgical procedure is greater than the value for code 0032,0034,0040 or 1807, the higher basic value is reported. See example below.

CLASSIFICATION	DESCRIPTION	CODE	UNITS
CONSULTATION UNITS	Pre-operative Risk Assessment	0151	16
ANAESTHETIC UNITS	Cholecystectomy	1675	6
	Laparoscopic Procedure	1807	0
	Anaesthetic Time X 49 minutes	0023	8

10.4. **2313** – Examination under anaesthesia when no other procedures are performed. This basic unit value may be used when a patient receives anaesthesia, but the planned surgical procedure is not performed for whatever reason.

SCENARIO: A patient is booked for an emergency procedure for fractured shaft of femur. After induction of anaesthesia the patient develops a fast-atrial fibrillation with haemodynamic compromise. The planned orthopaedic procedure is postponed, the patient stabilised in theatre and transferred to ICU.

SUGGESTION: As pertains to the procedure code (basic unit value) to be used, the anaesthesiologist is entitled to either code for the original procedure (0421 – fracture of femur) but keeping in mind that this may necessitate a motivation letter to the patient/funder or use code **2313** (see **Section 10.4**). All applicable consultation, procedure, time, and modifier codes should be coded for as per usual except the musculoskeletal modifier 5444, as the procedure was not performed.

10.5. The following are excluded from the Basic Unit Value:

10.5.1. All consultation and postoperative management codes e.g. the pre-anaesthetic risk assessment, in-hospital consultation codes and ICU codes



10.5.2. Any additional procedures performed during the anaesthetic e.g. placement of intra-arterial, central venous and pulmonary artery catheters, regional or neuraxial nerve blocks, nasogastric or orogastric intubation for any indication other than anaesthetic indications (e.g.: surgical, postoperative enteral feeding), management of a patient-controlled analgesic (PCA) pump and one lung ventilation

10.5.3. Unusual forms of monitoring e.g. use of trans-oesophageal echocardiography (TOE), utilising ultrasound to aid nerve block and line placement and use of a bronchoscope to confirm ET tube placement or perform fibre-optic intubation

10.5.4. Use of special equipment that is owned by the anaesthesiologist e.g. an ultrasound machine, target-controlled infusion pumps, PCA devices and disposable PCAs

10.5.5. Time-based codes (0023, 0039, 0011, 0018, 0019)

10.5.6. Ultrasound procedures performed.

11. CONSULTATION SERVICES

11.1. **0151 and 0152 and 0153** - Pre-operative assessment. This is face-to-face time spent with the patient, assessing prior medical and surgical history, medication and allergic history, prior anaesthetics, examination and discussion of anaesthetic techniques and risk, ordering of appropriate investigations and ordering of any pre-operative medication. This assessment may also be done in the theatre admission area, and whilst this is not ideal, it is understood that due to late admissions on the day of surgery and other explanations it is not always possible to see the patient in the ward.

11.2. If the pre-operative assessment is **not** followed by an operation (modifier **0024**), it would be regarded as a consultation and items **0173 or 0174 or 0175** for In-hospital consultations and items **0190 or 0191 or 0192** for consultations in own rooms, will apply.

11.3. Unscheduled or emergency consultation services, AT home or rooms (**0146**) and AWAY from home or rooms (**0147**). Only one of these items may be used as an add-on to the consultation service (**0151 or 0152 or 0153** and **0173** - First Hospital Consultation), if the procedure is for a bona-fide medical emergency where death or irreparable harm to the patient may result if there are undue delays in receiving appropriate medical treatment. (i.e.: treatment that cannot wait until the next scheduled/ elective list or within a restricted period of 24 hours from the time of diagnosis).

11.4. **0190 and 0191 and 0192 and 0193** - Consultation services provided at own consultation rooms (including pain and Anaesthetic clinic consultations). These codes are time and complexity based. See example below.

CONSULTATION CODE	DURATION OF CONSULTATION	COMPLEXITY	UNITS
0190	Up to 15 minutes	simple	15
0191	Up to 30 minutes	moderate	30
0192	More than 30 minutes	high	45
0193	More than 45 minutes	high	63,6

11.5. When writing special motivations for procedures and treatment (includes report on the clinical condition of a patient) is requested by or on behalf of a third-party funder or its agent, code **0133** is used. Where this report involves the physical presence of the patient for interview and examination, code **0173** (in-hospital) should be used. See section 12.



12. ANAESTHETIC CLINIC CODING

12.1. The appropriate consultation code to use in the Anaesthetic Clinic setting would be **0191** (See section 11.4) as most patients requiring a pre-operative consultation with an anaesthesiologist will have major comorbidities and/or are scheduled for a major surgical intervention.

12.2. In most consultations it will be required of the anaesthesiologist to write a report concerning the patient's fitness for the scheduled procedure and therefore it would be appropriate to use code **0133** as well. See example below.

CLASSIFICATION	DESCRIPTION	CODE	UNITS
CONSULTATION UNITS	Consultation of moderate complexity (more than 15 min)	0191	30
	Writing of report	0133	9

12.3. It remains appropriate for the anaesthesiologist performing the actual anaesthesia to use code 0151, irrespective of the fact that the patient has been seen in the Anaesthetic Clinic.

12.4. The following clinical procedures may be coded for and added to the account for the Anaesthetic Clinic visit:

12.4.1. **1192** – 5 Clinical units. Determination of **peak expiratory flow** only.

12.4.2. **1232** – 9 Clinical units. **Electrocardiogram (at rest)** performance plus interpretation (only appropriate if own equipment is used).

12.4.3. **1234** – 40 Clinical units. **Effort electrocardiogram** with the aid of a special bicycle ergometer / treadmill. Appropriate code to be used for 6-Minute Walk Test, if own equipment is used.

12.4.4. **5103** – 50 units (if own sonar machine is used) or 33,3 units is appropriate to use if a **FATE** (Focussed Assessed Transthoracic Echocardiography) examination is done during the consultation

12.4.5. 1230 and 1231 (interpretation of ECG without and with effort) is **not** appropriate to use in the Anaesthetic Clinic setting.

12.4.6. It is **not** appropriate to code for any other interpretations of any special investigations, as it is regarded as part of the consultation fee charged.

13. ANAESTHETIC TIME

13.1. Anaesthetic time is the actual time spent providing the anaesthesia service.

13.2. Time begins as the anaesthesiologist prepares the patient for anaesthesia care in the operating room or in an equivalent area.

SCENARIO: A patient develops airway complications while recovering from anaesthesia in the recovery room. The anaesthesiologist attends to the complication and it takes 15 minutes before the practitioner may leave the patient in the care of the recovery room staff. The official theatre time is thus 15 minutes less than the time the anaesthesiologist spent caring for the patient.

SUGGESTION: When anaesthetic time is calculated for the procedure one of two options will be appropriate. a) The time taken to handle the complication in recovery room is added to the anaesthetic time (this may necessitate a motivation to the patient/funder or b) the official theatre time is recorded as the anaesthetic time and the code **0109** (See section 10.1) is added to the account. The same principle applies when transporting a patient to the ICU. The time taken to transport and stabilise the patient may be added to the anaesthetic time, or the codes **0109** or **1204** (See section 10.2) or **1208** (See section 10.6) may be used additionally.

13.3. Time ends when the personal attendance of the anaesthesiologist is no longer required, and the patient can be safely placed in post-anaesthesia recovery under the supervision of nursing or other trained personnel.

TABLE 1

Anaesthetic time	Units (0023)	Unit increments
1 to 15 minutes	2	2 anaesthetic units per 15-minute intervals for the first 60 minutes
16 to 30 minutes	4	
31 to 45 minutes	6	
46 to 60 minutes	8	
61 to 75 minutes	11	3 anaesthetic units per 15-minute intervals after 60 minutes
76 to 90 minutes	14	
91 to 105 minutes	17	
106 to 120 minutes	20	
121 to 135 minutes	23	
136 to 150 minutes	26	
151 to 165 minutes	29	
166 to 180 minutes	32	
181 to 195 minutes	35	
196 to 210 minutes	38	

13.4. Time is reported in units based on defined time increments. For the first hour of anaesthesia, 2 anaesthetic units are allocated to each 15-minute period or part thereof, thereafter 3 anaesthetic units are allocated per each 15-minute period or part thereof. (See Table 1)

13.5. With some anaesthesia services, time is not reported additionally. A '+T' is designated after the base unit for procedures requiring time reported separately. Do not list time separately for procedures without this designation (refer to the eMDCM).

14. EMERGENCY OR UNSCHEDULED ANAESTHESIA SERVICES

14.1. Any bona fide, justifiable emergency procedure (all hours) will attract an additional 12 clinical units per half-hour or part thereof of the operating time for all members of the surgical team (See Table 2).

14.2. The conditions as outlined in the use of codes 0146 or 0147 applies (See section 11.3). See example below.

CLASSIFICATION	DESCRIPTION	CODE	UNITS
CONSULTATION UNITS	Pre-operative Risk Assessment	0151	16
	Emergency Consultation AWAY from Rooms	0147	14
ANAESTHETIC UNITS	Fracture: Femur Neck/Shaft - ORIF	0422	3
	Musculoskeletal Modifier	5445	5
	Anaesthetic Time X 49 minutes	0023	8
CLINICAL UNITS	Emergency / Unscheduled Procedure X 49 minutes	0011	24

TABLE 2

Unscheduled anaesthetic time	Units (0011)	Increments
1 to 30 minutes	12	12 clinical units per 30 minutes
31 to 60 minutes	24	
61 to 90 minutes	36	
91 to 120 minutes	48	
121 to 150 minutes	60	
151 to 180 minutes	72	
181 to 210 minutes	84	
211 to 240 minutes	96	
241 to 270 minutes	108	
271 to 300 minutes	120	
301 to 330 minutes	132	

15. OBSTETRIC ANAESTHESIA: GUIDELINE TO CODING

15.1. Labour epidural (2614)

15.1.1. Pre-anaesthetic risk assessment (0151) plus 0146 or 0147 (as appropriate).

15.1.2. Time charged using modifier **0023** of actual time spent attending to the patient, usually between 31-60 minutes (6 to 8 time units).

CLASSIFICATION	DESCRIPTION	CODE	UNITS
CONSULTATION UNITS	Pre-operative Risk Assessment	0151	16
	Emergency Consultation AWAY from Rooms	0147	14
ANAESTHETIC UNITS	Global Obstetric Care: Epidural Pain Relief	2614	6
	Anaesthetic Time X 45 minutes	0023	6
CLINICAL UNITS	Emergency / Unscheduled Procedure X 45 minutes	0011	24
	Management: Patient Controlled Analgesic Pump	1221	30

15.1.3. It is appropriate to code for unscheduled time (**0011**) if the epidural is unscheduled.



15.1.4. An indwelling epidural catheter inserted during a labour epidural is regarded as standard practice and therefore the use of code 2804 is not recommended. This recommendation is not applicable to non-labour epidurals as those are specifically employed for pain relief over prolonged periods.

15.1.5. If an epidural PCA and/or a continuous infusion of local anaesthetic is employed, the procedure code **1221** and **1220** (if PCA pump owned by practitioner) is appropriate. See example below.

15.2. **Epidural labour** patients progressing to caesarean or spinal for caesarean (**2615**): **Same practitioner** who placed the epidural involved.

15.2.1. No additional pre-anaesthetic consultation fee (0151) but 0146 or 0147 as appropriate.

15.2.2. Additional top-up times may be charged for the time spent with the patient prior to admission to the theatre.

15.2.3. Thereafter standard general anaesthetic reimbursement as if a separate procedure.

15.3. **Epidural labour** patients progressing to caesarean or spinal for caesarean (**2615**): **Different practitioner** from the one who placed the epidural.

15.3.1. Another consultation service is charged (0151) plus 0146 or 0147 as appropriate.

15.3.2. Thereafter standard general anaesthetic reimbursement as if a separate procedure.

15.4. The use of code 0039 (Control of blood pressure) during spinal or general anaesthesia for caesarean section.

15.4.1. The routine use of 0039 because of the expected blood pressure drop from a spinal anaesthetic and subsequent treatment thereof is not appropriate.

- 15.4.2. If the patient has a pre-existing pathological condition such as a cardiomyopathy, a critical valve lesion, hypovolaemic shock etc. which necessitates active haemodynamic support, it would be applicable to use 0039 (See Section 17.1)

SCENARIO: A pregnant patient is scheduled for an elective caesarean section. Her weight in the first trimester was 70 kg with a height of 1,6 meters (BMI 27,34). At full term she weighs 90 kg (BMI 35,16). Which weight should be used for the determination of anaesthetic risk?

SUGGESTION: As the anaesthetic risk associated with obesity relates to the time that the anaesthetic is administered, it would be correct to use the weight of 90 kg and thus coding for obesity (**0018**). Her normal non-pregnant weight has no bearing on the current anaesthetic risk (see **Section 19.1**).

16. MANAGEMENT SERVICES

- 16.1. **0109** – 15 consultation units: **Post-operative assessment and management** (hospital follow up consultation) . Anaesthesiology does not have a global fee component and therefore if cardio-respiratory, pain or any other assessment or intervention is necessary, this code will apply.
- 16.2. **1204** - 30 Clinical units. **ICU category 1**: Where the anaesthesiologist is responsible for intensively monitoring a patient peri-operatively, without active intervention. The code may be used once per calendar day.

Categories of ICU patients

Intensive care - Category 1: Cases requiring intensive monitoring in an ICU/high care setting without active system support.

Intensive care - Category 2: Cases requiring active system support. Ventilation may or may not be required for support.

Intensive care - Category 3: Cases with multiple organ failure or Category 2 patients requiring multidisciplinary intervention.

- 16.3. **1205** - 100 Clinical units. **ICU category 2**: Code to be used in the **first 24 hours** of active system support where the anaesthesiologist is the primary physician responsible for a patient.
- 16.4. **1206** – 50 Clinical units. **ICU category 2**: Code for **subsequent calendar days** of active system support where the anaesthesiologist is the primary physician responsible for a patient up to a period of 14 days.
- 16.5. **1207** – 30 Clinical; units. **ICU category 2**: Daily code to be used **after 2 weeks** of active system support where the anaesthesiologist is the primary physician responsible for a patient.
- 16.6. **1208** - 137 Clinical units. **ICU category 2** patient which requires **multidisciplinary intervention** or an **ICU category 3** patient. The primary physician responsible for the patient use 1208 once for the **first 24 hours** (only one physician may use 1208 per patient).
- 16.7. **1209** – 58 Clinical units. The anaesthesiologist takes part in the management of an **ICU category 2 or 3** patient but is not the primary physician. Use once for the **first 24 hours**.
- 16.8. **1210** – 50 Clinical units. The anaesthesiologist takes part in the management of an **ICU category 2 or 3** patient. Use for subsequent calendar days.

SCENARIO: A patient is admitted postoperatively to ICU for system support and the surgeon or a physician is taking primary responsibility for the patient in the postoperative period. It is expected of the anaesthesiologist to transport the patient to ICU, as well as setting up the ventilation, infusions, etc. He/she is also responsible for the pain management and sedation.

SUGGESTION: The primary practitioner should use codes 1205 / 1206 / 1208. In this case the anaesthesiologist would be justified in using code 1209. The codes 1205 / 1206 / 1208 may only be claimed by one practitioner per patient per 24-hour period. The value of code 0023 (anaesthetic time) will be determined by the time when the patient leaves the theatre as per usual. Alternatively, the anaesthesiologist may decide that the end of anaesthesia (0023) is when he/she leaves the ICU after stabilising the patient, but then it would be inappropriate to code for 1209, and 0109 should be used instead.

- 16.9. **1212 – ICU Ventilation: First 24 Hours** (75 Clinical Units). May only be used if the anaesthesiologist is the primary physician responsible for the ventilation of the patient.
- 16.10. **1213 – ICU Ventilation: Subsequent Days, per Calendar Day** (50 Clinical Units). May only be used if the anaesthesiologist is the primary physician responsible for the ventilation of the patient.
- 16.11. **1214 – ICU Ventilation: After 2 Weeks, per Calendar Day** (25 Clinical Units). May only be used if the anaesthesiologist is the primary physician responsible for the ventilation of the patient.
- 16.12. **1321** – 30 Clinical units. Stand-by fee for **coronary angioplasty**. Anaesthesiologist need not be present during the procedure but must be available for resuscitation or emergency CABG surgery.
- 16.13. **1211** – 50 Clinical units per 30 minutes for the first hour, 25 Clinical units per 30 minutes after one hour to a maximum of 150 Clinical units. **Cardio-respiratory resuscitation** performed (not during anaesthetic). To be used as stand-alone code without adding any procedures like CVC insertion, intubation, time etc. (See **Rule R**). Consultation codes may be added (0147/0146, 0173).

SCENARIO: The patient has a **cardiac arrest** intra-operatively, and resuscitation is commenced with a successful outcome, after which the patient is transferred to ICU. Which code should be reported for the arrest?

SUGGESTION: Code **1211** – Cardio-respiratory resuscitation specifies that the fee includes all necessary additional procedures including CV insertion, arterial line etc. If one codes for 1211 as well as the anaesthetic codes plus any additional procedures it would be technically correct for the funder to pay only for code 1211, with no payment for any additional codes. It is advisable to rather code for the applicable ICU support codes (**1205, 1208 or 1209**).

Rule R

In the case of ICU category 3 patients, the units for codes **1208, 1209** and **1210** include code **1211** (cardio-respiratory resuscitation). In other words, if 1208, 1209 or 1210 has been coded for a 24-hour period, code 1211 cannot be added to the account.

- 16.14. **1120** – 34 Clinical units. **Endotracheal intubation:** emergency procedure. Only to be coded for in situations where the intubation is **NOT** part of the anaesthesia.

Examples of the inappropriate use of 1120 (ET intubation)

- routine intubation during anaesthesia
- a second intubation during anaesthesia (resiting ET tube)
- intubation during a cardiac arrest (use of code 1211)
- difficult intubation with the use of intubation aids during an anaesthetic

17. MODIFIERS RELATED TO ANAESTHETIC TECHNIQUE

17.1. **0039 – Control of blood pressure:** Involves pharmacological control of perfusion pressures: All cases up to one hour: Add 3 Anaesthetic units, thereafter add 1 additional Anaesthetic unit per quarter hour or part thereof (See Table 3). As a general guideline the use of 0039 is appropriate where any vasoactive drugs are used regardless of monitoring, when required for the purposes of the surgery or cardiovascular and organ perfusion support of the patient (See section 15.4).

TABLE 3

Blood pressure control time	Units (0039)	Unit increments
1 to 60 minutes	3	<p>3 anaesthetic units for the first 60 minutes</p> <p>1 anaesthetic units per 15 minutes after 60 minutes</p>
61 to 75 minutes	4	
76 to 90 minutes	5	
91 to 105 minutes	6	
106 to 120 minutes	7	
121 to 135 minutes	8	
136 to 150 minutes	9	
151 to 165 minutes	10	
166 to 180 minutes	11	
181 to 195 minutes	12	
196 to 210 minutes	13	
211 to 225 minutes	14	
226 to 240 minutes	15	
241 to 255 minutes	16	
256 to 270 minutes	17	
271 to 285 minutes	18	
286 to 300 minutes	19	

Appropriate use of Blood Pressure control (0039) includes (but not limited to):

Improved surgical exposure

- mastoidectomy
- tympanoplasty
- spinal surgery
- major neck dissections,
- endoscopic sinus drainage
- mandibular or maxillary osteotomy
- total hip replacement
- total shoulder replacement

Maintain perfusion pressures

- shoulder surgery (any surgery where extreme positioning places vital organs at risk)
- cardiac surgery
- craniotomy for tumour/aneurysm
- major vascular surgery
- carotid endarterectomy
- major plastic free flaps
- vasoactive tumours – pheochromocytoma/carcinoid syndromes
- pre-eclamptic or eclamptic patients
- major organ transplantation (liver/kidney)
- liver resection
- shocked trauma cases on inotropic support
- any pre-existing medical condition which necessitates strict management of perfusion pressures

- 17.2. **0026** - 3 Anaesthetic units. **One lung ventilation**: Utilisation of one lung ventilation to improve surgical exposure and/or for lung isolation techniques.
- 17.3. **0037** - 3 Anaesthetic units. **Whole Body hypothermia**: This includes cases of cardio pulmonary bypass cases where a heat exchanger is used as well as where deep hypothermic arrest is employed.
- 17.4. **0038** – **Peri-operative blood salvage**: Add 4 Anaesthetic units for intra-operative blood salvage and 4 Anaesthetic units for post-operative blood salvage. Peri-operative blood salvage is appropriate for the collection of autologous blood intra-operatively and for the administering of salvaged blood (either from cell-saver or re-infusion drains) in the post-operative period.
- 17.5. **0041** – 3 Anaesthetic units: Utilisation of **hyperbaric pressurisation**.
- 17.6. **0042** – 3 Anaesthetic units: Utilisation of **extracorporeal circulation**.

18. MODIFIERS RELATED TO AGE

- 18.1. **0019** – 50% rule. Surgery on **neonates** up to and including 28 days after birth **or** low birth weight infants (less than 2500g) under general anaesthesia (**excluding circumcision**): A 50% increase in anaesthetic time units for anaesthesiologists as well as a 50% increase for all procedures (i.e. placements of CVP's, regional blocks) performed by the anaesthesiologist as part of the anaesthetic services provided. If the use of this code is indicated for low birth weight, the patient's weight at the time of delivering the anaesthesia should be recorded on the account.



SCENARIO: A neonate is born at 28 weeks and needs a procedure at age 8 weeks after birth. Thus, the neonate is only 32 weeks post conception, but falls outside the criteria of 28 days after birth for code 0019 to be valid. The child also weighs 2300g.

SUGGESTION: 0019 is still applicable as the coding rule states that either the neonate should be younger than 28 days post-delivery **or** the child should weigh less than 2500g. At least one of the two criteria should be present to report for this code. In this instance, post-conceptual age has no bearing on the applicability of code **0019**

- 18.2. **0044** - 3 Anaesthetic units. **Neonates** (i.e. up to and including 28 days after birth): to be added to the basic anaesthetic units for the procedure. This modifier is charged in addition to Modifier 0043 and 0019. For patients younger than one year of age but older than 28 days, only modifier 0043 is coded for. See example below.

CLASSIFICATION	DESCRIPTION	CODE	UNITS
CONSULTATION UNITS	Pre-operative Risk Assessment	0151	16
ANAESTHETIC UNITS	Omphalocele	1837	7
	Less than One Year of Age	0043	3
	Neonate (Less than 28 Days)	0044	3
	Anaesthetic Time X100 minutes	0023	17
	Anaesthetic Time X 100 minutes X 50%	0019	8,5

18.3. **0043** – 3 Anaesthetic units. Anaesthesia for patients **over 70 years of age or under one year of age**.

19. MODIFIERS RELATED TO PHYSICAL STATUS

19.1. **0018** – 50% rule. Surgical modifier for persons with a **BMI of 35 or greater** (calculated according to kg/m²): A 50% increase in anaesthetic time units for anaesthesiologists as well as a 50% increase for all procedures (i.e. placements of CVP's, regional blocks) performed by the anaesthesiologist as part of the anaesthetic services provided. The patient's weight, height and body mass index must be indicated on the account if the code 0018 is used. See example below.

BMI is calculated to the second decimal by convention and reported as such on the account.

e.g. if a patient has a BMI of 35.09, he/she would qualify for the use of 0018. Some funders would only calculate the rounded whole number which then would result of a BMI of 35, which disqualifies the use of 0018, and is incorrect.

CLASSIFICATION	DESCRIPTION	CODE	UNITS
CONSULTATION UNITS	Pre-operative Risk Assessment	0151	16
ANAESTHETIC UNITS	Fracture: Metacarpal - ORIF	0406	3
	Musculoskeletal Modifier	5441	1
	Anaesthetic Time X49 minutes	0023	8
	BMI=35,40 (50% of 0023)	0018	4
CLINICAL UNITS	Peripheral Nerve Block	2802	25
	BMI=35,40 (50% of 2802)	0018	12,5

19.2. **5431** – 0 Anaesthetic units. **ASA 1**: Normal healthy patient.

19.3. **5432** - 0 Anaesthetic units. **ASA 2**: Mild systemic disease.

Examples of modifier **5432** - **ASA 2** physical status would include:

- controlled hypertension which has no effect on the patient's normal lifestyle
- coronary artery disease that results in angina occurring on substantial exertion but not limiting normal activity; or
- diabetes which is well controlled and has minimal effect on normal lifestyle

19.4. **5433** – 1 Anaesthetic unit. **ASA 3**: Severe systemic disease, which limits normal activity.

Examples of modifier **5433** - **ASA 3** physical status would include:

- heart disease: a patient with ischaemic heart disease such that they encounter angina frequently on exertion thus significantly limiting activities.
- moderate to severe degrees of pulmonary or cardiac insufficiency: a patient who gets short of breath such that the patient cannot complete one flight of stairs without pausing; (dyspnoea grade 3)
- cerebrovascular disease causing a stroke and residual neurological deficit to the extent that it significantly limits normal activity.
- renal failure requiring regular dialysis

19.5. **5434** - 2 anaesthetic units. **ASA 4** - Severe systemic disease that is a constant threat to life.

Examples of modifier **5434** - **ASA 4** physical status would include:

- heart disease: unstable pattern angina or angina at rest.
- moderate to severe degrees of pulmonary or cardiac insufficiency: shortness of breath such that the patient cannot perform normal daily activities at rest; (dyspnoea grade 4)
- diabetes with severe end-organ damage such as severe visual impairment, peripheral vascular disease characterised by claudication at very short distances or at rest, renal failure.
- end-stage hepatic failure
- end-stage renal failure

19.6. **5435** - 3 Anaesthetic units. **ASA 5** - A moribund patient who is not expected to survive without the operation.

Examples of modifier **5435** - **ASA 5** physical status would include:

- a burst abdominal aneurysm with profound shock.
- major cerebral trauma with increasing intracranial pressure.
- pulmonary embolus causing haemodynamic instability.
- hypovolaemic shock of any cause.
- end-stage cardiac failure
- septic shock of any cause.
- ARDS

19.7. **5436** – 0 Anaesthetic units. **ASA 6** - A declared brain-dead patient whose organs are being removed for donor purposes.

20. MODIFIERS RELATED TO MUSCULOSKELETAL PROCEDURES

20.1. **5441** – 1 Anaesthetic unit. Musculoskeletal procedures specified with a “M” (Modifier) in the eMDCM, except where the procedure refers to the bones named in Modifiers 5442 to 5448.

20.2. **5442** – 2 Anaesthetic units. Musculoskeletal procedures involving the **shoulder / scapula / clavicle / humerus / elbow joint / upper 1/3 tibia / knee joint / patella / mandible** and/or **temporo-mandibular joint**.

20.3. **5443** - 3 Anaesthetic units. Musculoskeletal procedures involving the **maxillary** and/or **orbital bones**.

20.4. **5444** – 4 Anaesthetic units. Musculoskeletal procedures involving the **shaft of femur**.

20.5. **5445** - 5 Anaesthetic units. Musculoskeletal procedures involving the **spine (excluding the coccyx) / pelvis / hip** and/or **neck of femur**.

20.6. **5448** - 8 Anaesthetic units. Musculoskeletal procedures involving the **sternum and/or ribs** and musculoskeletal procedures which involve an intra-thoracic approach. **Not appropriate for open heart procedures.**

20.7. Musculoskeletal modifiers are only appropriate for procedures designated with the letter "M" added to the basic anaesthetic units (refer to the eMDCM)

20.8. If anaesthesia is administered for procedures on more than one category of bone, the modifier for the highest category of bone concerned is applicable.



20.9. In cases where a musculoskeletal modifier is applicable to the base unit AND the surgery involves the head/neck/shoulder area or is performed in a position other than supine or lithotomy, (See Section 10.3.1 and 10.3.2), BOTH applicable modifiers are applied to the base unit value. See example below.

CLASSIFICATION	DESCRIPTION	CODE	UNITS
CONSULTATION UNITS	Pre-operative Risk Assessment	0151	16
	Emergency Consultation AWAY from Rooms	0147	14
ANAESTHETIC UNITS	Fracture: Femur Neck/Shaft - ORIF	0422	3
	Musculoskeletal Modifier	5445	5
	Position other than Supine or Lithotomy	0032	2
	Anaesthetic Time X 49 minutes	0023	8
CLINICAL UNITS	Emergency / Unscheduled Procedure X 49 minutes	0011	24

21. PROCEDURES PERFORMED BY THE ANAESTHESIOLOGIST

21.1. It is appropriate for anaesthesiologists performing procedures, to use the appropriate consultation and procedure codes when rendering a service not related to the administration of an anaesthetic. If a procedure is performed on a patient that is unscheduled and not related to the administration of an anaesthetic, it is justified to use code **0011** for the time spent performing the procedure, but not code 0023. See example below.

21.2. If the performance of a procedure is related to the administration of an anaesthetic, the appropriate procedure code is added to the anaesthetic account.

21.3. **1215** – 25 Clinical units. Insertion of **arterial pressure cannula**.

21.4. **1218** – 25 Clinical units. Insertion of **central venous line**. Any approach*

21.5. **1216** – 50 Clinical units. Insertion of **Swan Ganz catheter**.

21.6. **1202** – 40 Clinical units. Insertion of **central venous catheter via peripheral vein in neonates**.

21.7. **1408** – 91 Clinical units. Insertion of **temporary dialysis line** (e.g. Cooks catheter). Any approach.

If anaesthesia or monitored anaesthesia care is required for the insertion and/or removal of a dialysis line or chemotherapy port, code **1408** is used as the basic unit value code with a value of 4 Anaesthetic units

CLASSIFICATION	DESCRIPTION	CODE	UNITS
CONSULTATION UNITS	Hospital Consultation	0173	17
	Unscheduled Consultation away from rooms	0147	14
CLINICAL UNITS	Unscheduled Procedure X 45 minutes	0011	24
	Dialysis Catheter Placement	1408	91
ULTRASOUND UNITS	Ultrasound Soft Tissue - 0083	5103	33,3

21.8. **0205** – 12 Clinical units: Intravenous treatment: Intravenous infusions (cut-down or push-in) (patients **under three years**): **Cut-down and/or insertion of cannula** - chargeable once per 24 hours. Chargeable by an anaesthesiologist provided it is not inserted in a theatre environment, i.e. ward, casualty, or ICU/High care areas.

21.9. **0206** – 6 Clinical units. Intravenous treatment: Intravenous infusions (push-in) (patients **over three years**): **Insertion of cannula** - chargeable once per 24 hours. Chargeable by an anaesthesiologist if they are **not** the attending doctor either in the ICU/High care or involved in the pre- and intra-operative management of the patient, as this fee is otherwise included in the fee for critical care services.

21.10. **1780** – 8 Clinical units: **Gastric and/or duodenal intubation**.

21.10.1. 1780 is appropriate to be used by the anaesthesiologist if a gastric or duodenal tube was inserted, either under anaesthesia or awake for a non-anaesthetic indication – e.g.: surgical indication e.g. during laparoscopic procedures of the upper abdomen to decompress the stomach or Critical care indication e.g. for enteral feeding of a ventilated patient



21.10.2. It is **not appropriate** to use 1780 if the gastric intubation was done for anaesthetic indications e.g. to reduce the risk of aspiration.

21.10.3. This code may also be used if the anaesthesiologist passes an oesophageal dilator.

21.11. **0113** – 45 Clinical units. **New born attendance**: Emergency attendance to new-born at all hours (once per patient) (items 0107, 0109, 0011, 0145, 0146 and/or 0147 may not be added to item 0113). The specialist fee is appropriate for anaesthesiologists.

21.12. **3636** – 100 Ultrasound Units: **Trans-oesophageal echocardiography** including passing the device. Specialist anaesthesiologists with demonstrated skill and experience may charge this code for recognised intra-operative decision making or diagnostic indications when surgery is not necessarily part of the treatment. In both cases this assumes that problem orientated, or a complete study is done, and advanced decision making is required.

21.13. **3637** – 78 Ultrasound units. + **Colour Doppler**. May be added onto any other regional ultrasound exam (e.g. 3636), but not to be added to items 3605, 5110, 5111, 5112, 5113 or 5114.

When anaesthesia or monitored anaesthesia care is required to perform an ultrasound study, code **5115** as the basic unit value code with a value of 3 Anaesthetic units is used



21.14. **5103** – 50 or 33,3 Ultrasound units (See section 25.2). **Ultrasound soft tissue**, any region. Ultrasound used for the placement of venous and/or arterial access, and nerve blocks and the performance of Focused Assessed Transthoracic Echocardiography (**FATE**) examination. This code may only be used once per case/visit.) (Also See Section 25.2)

Please note Rule 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

21.15. **0100** – 75 Clinical units. **Intra-aortic balloon pump**:) Where an anaesthesiologist would be responsible for **operating** an intra-aortic balloon pump. Appropriate as a once-off charge if the anaesthesiologist is in total control of the pump from insertion to removal. A daily charge is not appropriate.

21.16. **1356** – 188 Clinical units. **Insertion and/or removal of intra-aortic balloon pump** (modifier 0005 not applicable) . The practitioner inserting and/or removing the IABP may use the code.

If anaesthesia or monitored anaesthesia care is required for the insertion and/or removal of an intra-aortic balloon pump, code **1356** is used as the basic unit value code with a value of 15 Anaesthetic units

21.17. **1130** – 41,40 Clinical units. Direct laryngoscopy: Diagnostic laryngoscopy including biopsy (also to be applied when a flexible fibre-optic laryngoscope was used). Appropriate to be used by the anaesthesiologist if a **fibre-optic intubation** was performed.

21.18. **1132** – 65 Clinical units. **Bronchoscopy**: Diagnostic bronchoscopy. This code is applicable if a diagnostic bronchoscopy is performed or for the confirmation of the **correct placement of a double-lumen endotracheal tube or percutaneous tracheotomy tube**.

21.19. **1141** – 50 Clinical units. Placement of an **intercostal drain**.

21.20. **1127** – 90 Clinical units. Performing of **percutaneous tracheotomy**.

22. REGIONAL ANAESTHESIA AND PAIN MANAGEMENT

22.1. Routine post-operative pain management provided by the anaesthesiologist and/or surgeon is included in the global fee for the surgical procedure. Routine post-operative pain management includes oral, intramuscular, or intravenous medications.

22.2. Some procedures and/or patients require additional post-operative pain management, and this is frequently provided or supervised by an anaesthesiologist. These methods take the form of neuraxial analgesia and/or peripheral regional analgesia and/or a PCA device.

22.3. **2799** - 36 Clinical units: An **Intrathecal or spinal injection for pain** management. Also, applicable to **saddle blocks** This code should not be used if a single-shot spinal anaesthetic is the sole anaesthetic technique during the surgical procedure.

22.4. **2801** - 36 Clinical units: Placement of an **epidural or caudal block** ., and the performance of an **epidural blood patch**..

22.5. **2802** – 25 Clinical units: Performance of a **peripheral nerve block** (See Table 4).

22.6. **2800** – 36 Clinical units: Performance of a **plexus nerve block** is reported for more complex nerve blocks (See Table 4).

TABLE 4

PERIPHERAL BLOCK (2802)	PLEXUS BLOCK (2800)	EPIDURAL (2801)	SPINAL (2799)	OTHER
Any superficial infiltration block	Trigeminal nerve block	Epidural (any level)	Spinal (any level)	Intra-pleural block (1142)
Superficial nerve blocks of head and neck	Stellate ganglion block	Caudal	Saddle block	
Superficial cervical nerve block	Sphenopalatine ganglion block	Epidural blood patch		
Supra-hyoid block	Facial nerve block			
Trans-tracheal block	Maxillary nerve block			
Elbow block	Mandibular nerve block			
Wrist block	Deep cervical plexus block			
Digital ring block	Phrenic nerve block			
Pectoral block	Vagus nerve block			
Intercostal block – single level	Intercostal blocks – multiple levels			
Ilio-inguinal block	Superior hypogastric plexus block			
Ilio-hypogastric block	Paravertebral block			
Facia Iliaca block	Brachial plexus blocks (any approach)			
Obturator nerve block	Rectus sheath block			
Pudendal nerve block	Transversus abdominus plexus block			
Paracervical block	Coeliac plexus block			
Saphenous nerve block	Lumbar plexus block			
Popliteal nerve block	Psoas compartment block			
Ankle block	Femoral nerve block			
	Sciatic nerve block			

22.7. In cases where multiple nerve blocks are performed on the same patient during the same anaesthetic (e.g. bilateral Transversus Abdominus Plane blocks), modifier **0005** may be applied. Thus, the first TAP block will be coded at 100% of the value of 2800 of 36 units, the second TAP block will be coded with modifier 0005, with a value of 75% of 2800 or 27 units. If a third block is done the unit value will be 50% of 2800 or 18 units, and thereafter any additional blocks will have a value of 25% or 9 units. Modifier 0005 is not applicable to 5103 (Ultrasound guidance). See example below.

CLASSIFICATION	DESCRIPTION	CODE	UNITS
CONSULTATION UNITS	Pre-operative Risk Assessment	0151	16
ANAESTHETIC UNITS	Global Obstetric Care: Caesarean Section	2615	6
	Anaesthetic Time X 45 minutes	0023	6
CLINICAL UNITS	Plexus Block (TAP Block)	2800	36
	Plexus Block (TAP Block) – 0005 (75% value)	2800	27
ULTRASOUND UNITS	Ultrasound: Soft Tissue	5103	50

22.8. **2804** – 10 Clinical units: Inserting an indwelling **nerve catheter** during the performance of a spinal (2799), peripheral block (2802), plexus block (2800) or an epidural/caudal (2801).

Explanatory notes on Epidurals and Spinals

- If used as the sole anaesthetic technique, then the placement of the epidural (**2801**) or spinal (**2799**) is not used for and the coding should be as for a general anaesthetic.
- If an epidural is inserted for post-operative pain relief then **2801**, **2804** and **1221** (if appropriate) may be used. (note, NOT for a labour epidural where **2614** is used, and **2804** omitted)
- If an epidural is repeated at a different level due to a CSF leak at the time of initial insertion, it is considered as only one procedure.
- If it is re-sited on a different occasion, it becomes a separate and additional procedure.
- **2801** is appropriate for an epidural blood patch that is performed on the second or subsequent day after the inadvertent spinal tap.

22.9. **1220** – 30 Clinical units: Patient-controlled analgesia (**PCA**), **hire fee per 24-hour period** – only applicable when PCA device is owned by the Anaesthesiologist.

22.10. **0201** specifies the **cost of disposable material** used in a non-disposable PCA device and disposable PCA devices. May only be coded for if the practitioner supplies the material and/or PCA device.

Some indications for the use of a PCA (intravenous or epidural) or a continuous infusion via nerve/epidural catheter

- Thoracotomy/sternotomy
- Major vascular procedures
- Major intra-abdominal procedures (gastric and bowel surgery, renal surgery, hysterectomy, prostatectomy)
- Major orthopaedic procedures (major joint replacements, internal fixation of long bones)
- Major head and neck procedures (radical neck dissections)
- Major plastic and soft tissue procedures (mastectomy, extensive skin grafts, extensive burns, abdominoplasty)
- Pain relief in labour and post-caesarean section
- Acute Herpes Zoster
- Sickle cell crisis

- 22.11. **1221** – 30 Clinical units: **Professional fee for managing a PCA** for the first 24 hours. This code is also appropriate when an infusion of local anaesthetic via an epidural/nerve catheter is set up through a controllable infusion device.
- 22.12. Postoperative pain management services are not calculated based on time. These services are reported as a single, daily charge.
- 22.13. Procedures for chronic pain management (example epidural for pain) is only charged as a consultation service (0173-0175 or 0190-0192) plus the procedure code 2801 plus 2804 if appropriate – note there is no fee for anaesthetic time (See section 27).

23. MONITORED (STANDBY) ANAESTHESIA

- 23.1. Monitored anaesthesia care is defined as instances where an anaesthesiologist has been requested to provide specific services to a patient undergoing a planned procedure. The patient receives either local anaesthesia or no anaesthesia. However, the anaesthesiologist is required to provide pre-operative assessment, to remain in attendance during the procedure to monitor the patient and to administer additional anaesthesia should it be required and provide post-operative services as required.
- 23.2. The procedure should be assigned the applicable procedure code with time, modifying units, procedure units and consultation units being added as for general anaesthesia.
- 23.3. When the attending medical practitioner requests an anaesthesiologist to be present in the operating room to monitor vital signs and manage the patient on an anaesthesia level, even though the actual surgery is being done under local anaesthesia, calculations will be the same as if general anaesthesia had been administered (time + base unit value).

Standby anaesthesia is generally accepted without motivating documents for the following procedures:

- Vaginal delivery
- Subdural haematoma
- Vascular imaging and interventional procedures e.g. angioplasty, stents, embolectomy and filters
- Interventional radiology
- Patients with physical status ASA 3 or ASA 4 undergoing procedures where anaesthesia is not required but carries significant risk
- Insertion of a cardiac pacemaker, cardiac catheterisations and coronary angiograms and coronary stents
- Cataract extraction and/or lens implant

24. SEDATION

- 24.1. Sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or by light tactile stimulation. A distinction is also made between light sedation and deep sedation.
- 24.2. In light sedation, the patient responds to verbal or tactile stimuli, no airway intervention is required, spontaneous ventilation is adequate, and the cardio-vascular function is usually maintained.
- 24.3. In deep sedation purposeful response is only after repeated or painful stimuli, airway intervention may be required, spontaneous ventilation may be inadequate and cardio-vascular function is maintained.
- 24.4. Sedation is therefore seen as an anaesthetic technique. According to a HPCSA Ruling (April 1987 Vol 6 p 295) a medical practitioner 'was not permitted to perform procedures and simultaneously administer the anaesthetic'. If deep sedation was provided, a second practitioner had to be present to monitor the patient during the sedation period.

- 24.5. Sedation performed by the operator: No additional fee may be charged for the sedation if the operator performs it, except to remunerate him/her for the medicine used during the treatment if the operator supplies it. The sedation in this scenario is included in the fee for the procedure performed.
- 24.6. Sedation performed by the operator with a second person (anaesthesiologist) participating in the general care of a patient during a surgical procedure: The anaesthesiologist is remunerated at the usual anaesthetic rates. Thus, the operator under the "supervision of a second person" performs the sedation in this scenario. No fee is charged by the operator for performing the sedation. However, the anaesthesiologist on stand-by charges as for a general anaesthetic as appropriate.
- 24.7. Sedation performed by an anaesthesiologist (not the operator): The account is rendered as for general anaesthesia. Sedation is an anaesthetic technique that should be handled in the same way as for example an epidural anaesthetic.
- 24.8. **0020** – No unit value (descriptor only). This code may need to be used to indicate on the anaesthetic account that the procedure was performed in an unattached theatre suite as there may often not be an associated hospital theatre account.

25. USE OF OWN EQUIPMENT

25.1. **0007** – 15 Clinical units: **Use of own equipment in theatre**

- 25.1.1. When a practitioner utilises his/her own equipment (e.g. TCI infusion pump), code 0007 may be added to the account.
- 25.1.2. 0007 may only be used once per procedure irrespective of the number of items used (e.g. if two TCI pumps are used, 0007 are coded only once).
- 25.1.3. If the equipment in question are available for the anaesthesiologist's use within the facility that the service is being delivered, it is not considered appropriate to code for 0007, even if own equipment were used.

SCENARIO: An anaesthesiologist owns a TCI pump and uses it to give sedation in an out-of-hospital sedation unit as well as TCI anaesthesia in the hospital. The sedation unit does not have a TCI pump at the facility, whereas the hospital has a TCI pump available in every theatre.

SUGGESTION: It would be correct to add code **0007** (use of own equipment) to the account for those cases done in the sedation unit, but incorrect to add 0007 where the equipment was used in the hospital.

- 25.1.4. 0007 does not apply to PCA devices that are hired out for the use of patients. Code 1220 is appropriate in these cases (See section 22.9).
- 25.1.5. This rule applies to all additional equipment except ultrasound equipment where code 0083 is applicable (See section 25.2).
- 25.2. **0083** - Ultrasound equipment:
- 25.2.1. Where the ultrasound equipment being used to perform a soft tissue ultrasound or TOE examination is owned by a party other than the anaesthesiologist performing these procedures, the unit value of code 5103 and/or 3636 and/or 3637 is reduced by 33,33% - modifier 0083.
- 25.2.2. If the practitioner who performs the ultrasound examinations owns the equipment which is being used, the full unit value of codes 5103 / 3636 / 3637 is appropriate.

25.2.3. If the facility where the ultrasound procedures are being performed has ultrasound equipment readily available to the practitioner, the unit value of 5103 / 3636 / 3637 should be reduced by 33,33% irrespective of whose equipment were used. See example below.

SCENARIO: Anaesthesiologist A (hospital A) and anaesthesiologist B (hospital B), do ultrasound-guided regional anaesthesia on a regular basis. Hospital A has adequate ultrasound equipment available in theatre, whereas hospital B has no such equipment.

Both anaesthesiologists own their own ultrasound equipment.

RECOMMENDATION: When practitioner A codes for ultrasound use (code **5103**) the value of 5103 will be 33,3 units i.e. he should use code **0083** additionally in the account, whereas practitioner B may use 5103 at the full value of 50 units.

As modifier 0083 implies a modification of the unit value of a specific code, by convention the modifier is specified within the same line in the account as the code which it reduces. See example below.

CLASSIFICATION	DESCRIPTION	CODE	UNITS
CONSULTATION UNITS	Hospital Consultation	0173	17
	Unscheduled Consultation away from rooms	0147	14
CLINICAL UNITS	Unscheduled Procedure X 45 minutes	0011	24
	Dialysis Catheter Placement	1408	91
ULTRASOUND UNITS	Ultrasound Soft Tissue - 0083	5103	33,3

25.2.4. It is not considered appropriate to use code 0007 along with the use of own ultrasound equipment.

26. ASSISTANT ANAESTHESIOLOGIST / ANAESTHETIST

26.1. When it is necessary to have a second anaesthesiologist the time unit value for the second anaesthesiologist shall be the same value for the first hour, and thereafter at 80% of the principal anaesthesiologist's value. Time coded is for the actual time in attendance.

26.2. Consultation codes, modifiers 0037 to 0044 and musculoskeletal modifiers 5441 to 5448 are **not** coded for by the assistant anaesthesiologist.

26.3. Any intra-operative procedure performed by the assistant (e.g. an ultrasound for regional anaesthesia – 5103) is coded by the anaesthesiologist who performs the procedure.

26.4. The modifier for a BMI above 35 (**0018**), unscheduled time units (**0011**) and neonatal procedures (**0019**) are coded for in the same manner as the time code 0023 by the assistant anaesthesiologist.

26.5. The total unit value of modifier **0029** will not be less than 7 units (modifier **0035** – see section 9.7)).

26.6. The code 0029 and its corresponding values must be submitted within the same account as the that of the primary anaesthesiologist.

27. CHRONIC PAIN MANAGEMENT SERVICES

27.1. Chronic pain management services are not anaesthesia services. These are distinct services frequently performed by anaesthesiologists who have additional training in pain management procedures.

27.2. Pain management services are reported following the same rules as those for surgical procedures.

27.3. Pain management services include consultative services, trigger point injections, spine and spinal cord injections and nerve blocks.

27.4. Each code for pain management services should have a specific fee selected from the appropriate codes for the services or procedures rendered. In other words, no adjustments are made based on time, physical status or qualifying circumstances. These codes may be the same as those used for nerve blocks during anaesthesia. See Table 4.

27.5. **2791** - 65 Clinical units. **Trigeminal ganglion: Injection of cortisone.**

27.6. **2793** - 170 Clinical units. **Trigeminal ganglion: Coagulation through high frequency.**

27.7. **2927** - 320 Clinical units. **Rhizotomy: Extradural, but intraspinal.** Code used for lumbar radio-frequency nerve ablations.

27.8. **2805** - 35 Clinical units. **Alcohol injection in peripheral nerves for pain: Bilateral.**

27.9. **2849** - 20 Clinical units. **Sympathetic block: Other levels: Unilateral.** E.g. lumbar sympathetic pain block for CRPS.

27.10. **2851** - 35 Clinical units. **Sympathetic block: Other levels: Bilateral.**

27.11. **2853** - 20 Clinical units. **Sympathetic block: Diagnostic/Therapeutic.** May be intercostal / brachial / peripheral or Stellate ganglion.

28. GUIDELINE TO EVENT BASED BILLING (GLOBAL OR FIXED FEES)

28.1. Definitions

28.1.1. **Event Based Fee** – refers to the fee associated with a specified clinical event per professional service rendered.

This fee will include all peri-operative services irrespective of modifiers applicable or extra procedures performed and should be stipulated in the contract. e.g. the Event Based Fee for Anaesthesia may be R XXXXXX, XX for an uncomplicated unilateral knee replacement. The Event Based Fee is distinguished from Global, Fixed, or Bundled fees by the following:

28.1.1.1. The fee per event is contracted between the patient and the professional delivering a specified service.

28.1.1.2. The fee may be negotiated with a third-party funder recognised by the Council for Medical Schemes as such (Medical Aids) to be paid on behalf of the patient.

28.1.1.3. No other professional or third parties are involved in determining or distributing any fees.

28.1.2. **Global Fee OR Fixed Fee** -may be defined differently according to what the party describing the Global or Fixed Fee is intending:

28.1.2.1. Defined as an Event Based Fee (See section 28.1.1).

28.1.2.2. Defined as the total expenditure for all professional services associated with a specified clinical event. This Global Fee is usually paid to the "team leader" e.g. the surgeon which then decides how to distribute the fee amongst the various professionals e.g. the Global Fee for the Anaesthetic, Surgical, and Physiotherapy services may be R XXXXXX, XX for an uncomplicated unilateral knee replacement. As at the date of drafting this guideline, this practice is deemed unethical by SASA and the HPCSA.

28.1.2.3. Defined as the total expenditure for all clinical services associated with a specified clinical event, including hospitalisation. This Global Fee is usually paid to the Hospital which then distributes the fee amongst the various professionals according to an agreed amount per event per professional. As at the date of drafting this guideline, this practice is deemed unethical by SASA and the HPCSA.

28.1.3. **Bundled Fee or Service** - may be defined differently according to what the party describing the Global or Fixed Fee is intending

28.1.3.1. Defined as the total expenditure for all professional services associated with a specified clinical event. This Bundled Fee is usually paid to the "team leader" e.g. the surgeon which then decides how to distribute the fee amongst the various professionals e.g. the Bundled Fee for the Anaesthetic, Surgical, and Physiotherapy services may be R XXXXXX, XX for an uncomplicated unilateral knee replacement. As at the date of drafting this guideline, this practice is deemed unethical by SASA and the HPCSA

28.1.3.2. Defined as the total expenditure for all clinical services associated with a specified clinical event, including hospitalisation. This Global Fee is usually paid to the Hospital which then distributes the fee amongst the various professionals according to an agreed amount per event per professional. As at the date of drafting this guideline, this practice is deemed unethical by SASA and the HPCSA.

28.2. Determining the value of the Event Based Fee (EBF)

28.2.1. Utilise data from their practice and determining the average fee that was billed for the specific clinical event over a period of at least 12 months previously, **OR**

28.2.2. Use the method as demonstrated in ANNEXURE 4 to determine the various units for consultation, anaesthesia, clinical procedures, and ultrasound per clinical event, and applying the practice's standard RCF values to those units (See section 9.5).

28.2.3. If there is a requirement to evaluate patients beforehand for peri-operative fitness e.g. an anaesthetic clinic consultation, the value of codes 0191 and 0133 must be added to the EBF (See section 12).

28.2.4. If there is a requirement to report on clinical information about the case to funders or administrators, the value of code 0133 must be added to the EBF (See section 11.5).

28.2.5. If there is a requirement for any postoperative services such as anaesthetic follow-up patient visit, the value of code 0109 must be added to the EBF (See section 16.1).

28.3. Reporting of EBF Events

28.3.1. Billing for an EBF event would involve using a specific code that is recognisable by the funder and the practice administration as such. The following coding convention is recommended by SASA:

28.3.2. The capital letters "AN" is added as a prefix to the procedure code to which the EBF event is applicable e.g. AN0637 would be used for an uncomplicated primary Hip Replacement and AN2259 will apply to a Robotic Prostatectomy.

28.3.3. It is recommended that only the AN code be used with an attributed Rand value. For data and record keeping purposes it is recommended that all other codes applicable be reported on the invoice with a zero value, ie:

CLASSIFICATION	DESCRIPTION	CODE	VALUE
EVENT BASED FEE	KNEE: TOTAL REPLACEMENT	AN0646	R XXXXX

consultation, time, modifier, clinical or ultrasound codes.

28.3.4. The value of the EBF code will be the contracted value of that code as specified in the EBF Contract for that calendar year (See section 28.4)

28.3.5. It is recommended that through comprehensive code reporting per invoice, the member keeps a record of every EBF event with the conventional codes added as per modifiers, time, clinical procedures etc. and use this data to

create an average cost to the member for the following calendar year when the EBF contract value is to be negotiated with the funders.

28.4. Ethical and Legal requirements of an EBF contract

- 28.4.1. A valid EBF contract can only be concluded between a medical funder and/or medical funder administrator and the medical professional that will deliver the clinical service.
- 28.4.2. It is unethical to conclude an EBF contract between two medical professionals or between a health facility or hospital group, and a medical professional or between a third-party funder that is not a medical scheme, and a medical professional.
- 28.4.3. It is unlawful for a third party to be included in any Fixed Fee or Global Fee arrangement concluded between two parties without the express and signed agreement of the third party to all the clauses of the arrangement.
- 28.4.4. The EBF contract must clearly stipulate that the primary contractual agreement will be between the patient and the medical professional, superseding any other contractual responsibilities that the two signatories agree to.
- 28.4.5. The value of the EBF agreed upon must be within a reasonable percentage of the average value that will be charged by the practitioner at his/her normal Fee-for-Service rate, plus the fees for any additional services that may be required in terms of the contract (See 28.2.3, 28.2.4 and 28.2.5). Specifically, exploitation of the professional or the patient financially (or their funding mechanism) should be guarded against.
- 28.4.6. The EBF must be charged for all cases specified for a clinical event irrespective of patient age, physical status, or funder responsible.
- 28.4.7. The EBF contract must specify for which clinical event/s the contract applies to.
- 28.4.8. Any exclusion criteria that may be applicable to the clinical event/s stipulated in the contract must be clearly defined.
- 28.4.9. Clinical responsibility must be clearly defined in the EBF contract e.g. the anaesthesiologist will be responsible for a pre-operative fitness assessment, supplying a motivation to the funder/administrator with regards to the fitness of the patient, intra-operative anaesthetic management, post-operative physiological care for 24 hours after the procedure, and participation in clinical data collection.
- 28.4.10. Clinical guidelines and/or protocols should be aligned to the discipline's relevant professional society clinical guidelines and/or protocols or international best practice guidelines where no societal guideline exists..
- 28.4.11. The specified clinical guideline must be published in full as an addendum to the EBF contract.
- 28.4.12. The relevant Professional Society must be the only body authorised to process any peer-review issues (, ethical, legal, or clinical) that may arise from the services delivered under the EBF contract. Financial peer review may be requested of a society with member and funder consent and within the prescripts of the Competition Act 89 of 1998 as amended.
- 28.4.13. The EBF contract must not contain any incentives to under service or over service a patient.
- 28.4.14. The monetary value of the EBF must be clearly specified in the contract.
- 28.4.15. The period of validity of the EBF contract must clearly be stated in the contract.
- 28.4.16. Annual review of all aspects related to the contract is strongly recommended.
- 28.4.17. A clearly specified exit procedure must be defined in the EBF Contract.

Annexure 1 General Information and Informed Consent

Disclaimer for Annexure 1: The following is an example of a contract specific to a particular practice within the Republic of South Africa. A wide variety of contracts exist tailored to and specific to each unique practice. The intention of sharing this document is to provide an example or framework within which each member may construct his/ her own consent documents. No warranty, guarantee or limitation of liability is provided for through this example. Members are strongly advised to obtain legal advice prior to utilising their own formulated consent documents. The authors and SASA cannot be held individually or severally liable for any harm or negative consequence that may arise from the application or use in total or in part of this consent document example.

GENERAL INFORMATION

1. No food or liquids (excluding clear fluids) may be taken by mouth for at least six (6) hours before the anaesthetic
2. Water or apple juice may be taken up to two (2) hours before the anaesthetic
3. It is against the law to drive a motor vehicle or operate heavy machinery for 24 hours after the anaesthetic
4. It is recommended that no alcohol be taken, and no important decisions made within 24 hours after the anaesthetic

INFORMED CONSENT FOR ANAESTHESIA

1. I understand that a qualified Anaesthesiologist (specialist in Anaesthesia) will take responsibility for my peri-operative care
2. I understand that during the procedure, my physical and surgical conditions may alter and require changes in the management of my anaesthesia. This will be done with my safety as the first consideration
3. I understand that the transfusion of blood and/or other blood products may be required during the procedure
4. I understand that an incident-free anaesthetic cannot be guaranteed
5. I understand that anaesthetic staff and equipment are supplied by the hospital and cannot be guaranteed by the anaesthesiologist. Equipment is checked daily
6. I understand that no guarantee can be given regarding my response to drugs administered during the anaesthetic
7. I understand that this informed consent is only valid for the proposed procedure I consented to
8. I understand that I may withdraw this consent at any time before the commencement of the anaesthetic
9. I understand that receiving anaesthesia will have certain risks. Risks and complications may include, but is not limited to:
 - General anaesthesia: Sore throat, hoarseness, injury to airway and teeth, nausea and vomiting, pneumonia and other lung problems, injury to nerves and blood vessels, adverse drug reactions, awareness under anaesthesia, brain damage and loss of life.
 - Regional anaesthesia and spinal/epidural: As for general anaesthesia as well as low blood pressure, headache, minor pain and discomfort during the procedure, residual weakness and loss of sensation, infection, failed technique with conversion to general anaesthesia

Signed by..... Relationship to Patient.....
 initials and surname

Signed on.....at
 date signature

Annexure 2 Contract with the Anaesthesiologist

Disclaimer for Annexures 2 and 3: The following is an example of a contract specific to a particular practice within the Republic of South Africa. A wide variety of contracts exist tailored to and specific to each unique practice. The intention of sharing this document is to provide an example or framework within which each member may construct his/ her own consent documents. No warranty, guarantee or limitation of liability is provided for through this example. Members are strongly advised to obtain legal advice prior to utilising their own formulated consent documents. The authors and SASA cannot be held individually or severally liable for any harm or negative consequence that may arise from the application or use in total or in part of this consent document example.

CONTRACT WITH THE ANAESTHESIOLOGIST

1. I understand that the anaesthetic account is separate from the hospital and surgeon accounts
2. I accept responsibility for the full amount of the anaesthetic account
3. I understand that the correct reference number must accompany all EFT payments, and that the anaesthesiologists will not be held responsible for any costs associated with payments that could not be allocated due to incorrect reference numbers
4. I declare that the anaesthetic account will **not** form part of any administrative order that exists on the guarantor's name
5. I declare that all personal information supplied by me is true and correct
6. I accept responsibility for all legal and tracing costs that may be incurred due to non-payment according to attorney and client scales
7. I declare that, in the case that I am not the guarantor, I have the permission of the guarantor to sign this contact
8. I declare that I have read and understood the complete contents of this document and that I accept all terms and conditions as specified in the Billing Policy (see Reverse)

Signed by..... Relationship to Patient.....
initials and surname

Signed on.....at
date signature Anaesthesiologist

Annexure 3 Billing Policy and Cost Estimate *(see Disclaimer Annexure 2)*

BILLING POLICY

A. Coding

1. The Practice determines the costs associated with the provision of anaesthetic services by using the coding rules as determined by the South African Society of Anaesthesiologists (SASA) and the South African Medical Association (SAMA)
2. The Practice regard the Coding Guidelines published by SASA (most recent edition) and the Medical Doctors Coding Manual published by SAMA (most recent edition) as the only legitimate source documents when determining coding rules for the practice.
3. Medical Aids may dispute the validity of the codes as used by the Practice. The Practice will assume that the rules as set out in the source documents (SASA and SAMA) are the correct and ethical interpretation.

B. Tariff Determination

- 1 The Practice Standard Tariff is determined by taking the value of the service, the cost to the practice to deliver the service and local economic factors into account. The standard tariff is charged to all patients irrespective of age, economic circumstances or funder involved as required by the Consumer Protection Act

THE PRACTICE STANDARD TARIFF FOR 2018

TARIFF	CONSULTATION UNITS	ANAESTHETIC UNITS	CLINICAL UNITS	ULTRASOUND UNITS
The Practice	R XXX,XX	R XXX,XX	R XXX,XX	R XXX,XX
Discovery Fund	R XXX,XX	R XXX,XX	R XXX,XX	R XXX,XX
GEMS Fund	R XXX,XX	R XXX,XX	R XXX,XX	R XXX,XX

C. Account Administration

1. The administration of an account remains the responsibility of the patient and/or guarantor.
2. In cases where a funder's administration is substandard, the Practice will not submit the account to the funder but to the patient/guarantor.

The Practice DOES **NOT** HANDLE THE ADMINISTRATION FOR THE FOLLOWING MEDICAL AIDS AND ENTITIES

- i) **Funder A**
- ii) **GAP Cover Companies**
- iii) **Entity A**

Patients that belong to these entities must submit their accounts independently (see Terms of Payment below)

D. Terms of Payment

1. The patient and/or guarantor and/or employer (IOD cases) remains responsible for the full amount of the account
2. Terms of full payment is strictly 30 (thirty) days after service delivery
3. After the 30-day period has expired, the account will be handed to a lawyer for debt recovery.
4. The Practice may only accept payment from the patient and/or the patient's guarantor and/or a medical funder registered as such with the Council of Medical Schemes. The Practice does not accept any direct payment from another doctor, hospital, insurance company or any other entity that acts on behalf of funders or the patient

E. Medical Aid payments and Motivations

The Practice does NOT supply motivations to Medical Aids and/or Hospitals for the use of any medication and/or procedures and/or equipment that may be required during the anaesthetic

Examples of medication and/or procedures and/or equipment where the Medical Aid may refuse payment or require motivation include (list not complete):

- Gastroscopy/Colonoscopy/Radiological/Cosmetic/Sterilisation procedures
- Drug A
- Monitoring device A
- Procedure A
- Codes 1,2,3,4

In case the Medical Aid refuses to pay for clinically accepted treatments, you are advised to contact the Council of Medical Schemes (www.medicalschemes.com)

COST ESTIMATE

If you require a cost estimate for the procedure you may contact the offices of the practice at 555-55555 or Email at XX.XX.co.za

Annexure 4 Event based fee calculations based on practice data

PLEASE TAKE NOTE:

- These calculations and percentages are based on data from a large partnership over a 24-month period.
- It may not be applicable to every practice. Members should compile their own data every 12 months to ensure accuracy and compliance with new practice trends (See section 28.3.5)
- See sections 8.12 / 9.3 / 9.4 / 9.5 / 28 for further information
- It is suggested that the final event based fee may consist of all the components or exclude all optional component and itemise these separately. Each SASA member is empowered to conclude such a contract with their unique locality specific requirements and costs with patients or their chosen funder.
- It is highly recommended that members report the final agreed to event based code as well as all codes that are relevant to the services delivered. (See Section 28 of these guidelines.)

Code AN3047 or Code AN3049 – cataract surgery (standby anaesthesia)				
Consultation units		15		16 X RCF1
Anaesthetic units		13		13 X RCF2
Clinical units		0		0 X RCF3
Ultrasound units		0		0 X RCF4
Anaesthetic clinic visit required(optional)		39		39 X RCF1
Administrative requirements (optional)		9		9 X RCF1
Postoperative follow up required (optional)		15		15 X RCF1
Own equipment hire (optional code 0007))		15		15 X RCF3
EVENT BASED FEE = (CONSULTATION UNITS MULTIPLIED BY RCF1) + (ANAESTHETIC UNITS MULTIPLIED BY RCF2) + (CLINICAL UNITS MULTIPLIED BY RCF3) + (ULTRASOUND UNITS MULTIPLIED BY RCF4)				R XXXX,XX
Derived from				
CODE	DESCRIPTION	AVERAGE TIME	PERCENTAGE USED	TOTAL UNITS
0151	Risk assessment	n/a	100%	16 consultation units
0023	Anaesthetic. time	32 minutes	100%	6 anaesthetic units
3047 3049	Cataract extracapsular OR Lenticulus placement	n/a	100%	7 anaesthetic units

Code AN0637 – Primary Hip replacement

	units	own ultrasound	hospital ultrasound
Consultation units	17,35	17,35 X RCF1	17,35 X RCF1
Anaesthetic units	35,94	35,94 X RCF2	35,94 X RCF2
Clinical units	19,80	19,80 X RCF3	19,80 X RCF3
Ultrasound units	variable	20 X RCF4	13,33 X RCF4
Anaesthetic clinic visit required(optional)	39	39 X RCF1	39 X RCF1
Administrative requirements (optional)	9	9 X RCF1	9 X RCF1
Postoperative follow up required (optional)	15	15 X RCF1	15 X RCF1
Own equipment hire (optional code 0007))	15	15 X RCF3	15 X RCF3
EVENT BASED FEE = (CONSULTATION UNITS MULTIPLIED BY RCF1) + (ANAESTHETIC UNITS MULTIPLIED BY RCF2) + (CLINICAL UNITS MULTIPLIED BY RCF3) + (ULTRASOUND UNITS MULTIPLIED BY RCF4)		R XXXX,XX	R XXXX,XX

Derived from

CODE	DESCRIPTION	AVERAGE TIME	PERCENTAGE USED	TOTAL UNITS
0151	Risk assessment	n/a	100%	16 consultation units
0147	Unscheduled consultation	n/a	9%	1,35 consultation units
0023	Anaesthetic. time	133 minutes	100%	23 anaesthetic units
0637	Hip Replacement Primary	n/a	100%	3 anaesthetic units
0032	Position modifier	n/a	100%	2 anaesthetic units
5445	Modifier: Hip	n/a	100%	5 anaesthetic units
0039	Blood Pressure Control	133 minutes	64%	5,12 anaesthetic units
0043	Age <1 />70	n/a	35%	1,05 anaesthetic units
0018	BMI > 35	133 minutes	15%	1,73 anaesthetic units
5433	ASA 3 patient	n/a	4%	0,04 anaesthetic units
2800	Femoral Block	n/a	40%	14,4 clinical units
0011	Unscheduled time	133 minutes	9%	5,4 clinical units
5103	Ultrasound (own equipment) OR Ultrasound (hospital equipment)	n/a	40%	20 ultrasound units OR 13,33 ultrasound units

Code AN0646 – Primary Knee replacement

	units	own ultrasound	hospital ultrasound
Consultation units	16	16 X RCF1	16 X RCF1
Anaesthetic units	32,31	32.31 X RCF2	32.31 X RCF2
Clinical units	21,6	21.6 X RCF3	21.6 X RCF3
Ultrasound units	variable	30 X RCF4	19.98 X RCF4
Anaesthetic clinic visit required(optional)	39	39 X RCF1	39 X RCF1
Administrative requirements (optional)	9	9 X RCF1	9 X RCF1
Postoperative follow up required (optional)	15	15 X RCF1	15 X RCF1
Own equipment hire (optional code 0007))	15	15 X RCF3	15 X RCF3
EVENT BASED FEE = (CONSULTATION UNITS MULTIPLIED BY RCF1) + (ANAESTHETIC UNITS MULTIPLIED BY RCF2) + (CLINICAL UNITS MULTIPLIED BY RCF3) + (ULTRASOUND UNITS MULTIPLIED BY RCF4)		R XXXX,XX	R XXXX,XX

Derived from

CODE	DESCRIPTION	AVERAGE TIME	PERCENTAGE USED	TOTAL UNITS
0151	Risk assessment	n/a	100%	16 consultation units
0023	Anaesthetic. time	130 minutes	100%	23 anaesthetic units
0646	Knee Replacement Primary	n/a	100%	3 anaesthetic units
5442	Modifier: knee	n/a	100%	2 anaesthetic units
0043	Age <1 />70	n/a	24%	0,72 anaesthetic units
0018	BMI > 35	133 minutes	31%	3,56 anaesthetic units
5433	ASA 3 patient	n/a	3%	0,03 anaesthetic units
2800	Femoral Block	n/a	60%	21,6 clinical units
5103	Ultrasound (own equipment) OR Ultrasound (hospital equipment)	n/a	60%	30 ultrasound units OR 19,98 ultrasound units

Code AN1341TAVI – Transcatheter Aortic Valve Implantation

	units	own ultrasound	hospital ultrasound
Consultation units	16	16 X RCF1	16 X RCF1
Anaesthetic units	72,52	72,52 X RCF2	72,52 X RCF2
Clinical units	67,5	67,5 X RCF3	67,5 X RCF3
Ultrasound units	variable	75 X RCF4	66,67 X RCF4
Anaesthetic clinic visit required(optional)	39	39 X RCF1	39 X RCF1
Administrative requirements (optional)	9	9 X RCF1	9 X RCF1
Postoperative follow up required (optional)	15	15 X RCF1	15 X RCF1
Own equipment hire (optional code 0007))	15	15 X RCF3	15 X RCF3
EVENT BASED FEE = (CONSULTATION UNITS MULTIPLIED BY RCF1) + (ANAESTHETIC UNITS MULTIPLIED BY RCF2) + (CLINICAL UNITS MULTIPLIED BY RCF3) + (ULTRASOUND UNITS MULTIPLIED BY RCF4)		R XXXX,XX	R XXXX,XX

Derived From

CODE	DESCRIPTION	AVERAGE TIME	PERCENTAGE USED	TOTAL UNITS
0151	Risk assessment	n/a	100%	16 consultation units
0023	Anaesthetic. time	200 minutes	100%	38 anaesthetic units
1341	Aortic Valve Replacement	n/a	100%	15 anaesthetic units
0039	Blood Pressure Control	200 minutes	100%	13 anaesthetic units
0043	Age <1 />70	n/a	100%	3 anaesthetic units
0018	BMI > 35	200 minutes	8%	1,52 anaesthetic units
5434	ASA 4 patient	n/a	100%	2 anaesthetic units
1215	Arterial Line	n/a	100%	25 clinical units
1218	CVP	n/a	50%	12,5 clinical units
1204	ICU Category 1, per 24 hours	n/a	100%	30 clinical units
3636	TOE	n/a	50%	50 ultrasound units
5103	Ultrasound (own equipment) OR Ultrasound (hospital equipment)	n/a	50%	25 ultrasound units OR 16,67 ultrasound units

Code AN2259ROBOT – Robot Prostatectomy

	units	own ultrasound	hospital ultrasound
Consultation units	16	16 X RCF1	16 X RCF1
Anaesthetic units	52,07	52,07 X RCF2	52,07 X RCF2
Clinical units	30	30 X RCF3	30 X RCF3
Ultrasound units	variable	35 X RCF4	23,31 X RCF4
Anaesthetic clinic visit required(optional)	39	39 X RCF1	39 X RCF1
Administrative requirements (optional)	9	9 X RCF1	9 X RCF1
Postoperative follow up required (optional)	15	15 X RCF1	15 X RCF1
Own equipment hire (optional code 0007))	15	15 X RCF3	15 X RCF3
EVENT BASED FEE = (CONSULTATION UNITS MULTIPLIED BY RCF1) + (ANAESTHETIC UNITS MULTIPLIED BY RCF2) + (CLINICAL UNITS MULTIPLIED BY RCF3) + (ULTRASOUND UNITS MULTIPLIED BY RCF4)		R XXXX,XX	R XXXX,XX

Derived From

CODE	DESCRIPTION	AVERAGE TIME	PERCENTAGE USED	TOTAL UNITS
0151	Risk assessment	n/a	100%	16 consultation units
0023	Anaesthetic. time	200 minutes	100%	38 anaesthetic units
2259	Radical Prostatectomy	n/a	100%	8 anaesthetic units
0039	Blood Pressure Control	200 minutes	30%	3.9 anaesthetic units
0043	Age <1 />70	n/a	9%	0,27 anaesthetic units
0018	BMI > 35	200 minutes	10%	1,9 anaesthetic units
1215	Arterial Line	n/a	50%	12,5 clinical units
1218	CVP	n/a	70%	17,5 clinical units
5103	Ultrasound (own equipment) OR Ultrasound (hospital equipment)	n/a	70%	35 ultrasound units OR 23,31 ultrasound units

Code AN2614 – Labour Epidural

		units		
Consultation units		29,58	29,58 X RCF1	
Anaesthetic units		12,24	12,24 X RCF2	
Clinical units		53,28	53.28 X RCF3	
Administrative requirements (optional)		9	9 X RCF1	
Postoperative follow up required (optional)		15	15 X RCF1	
Own equipment hire (optional code 0007))		15	15 X RCF3	
EVENT BASED FEE = (CONSULTATION UNITS MULTIPLIED BY RCF1) + (ANAESTHETIC UNITS MULTIPLIED BY RCF2) + (CLINICAL UNITS MULTIPLIED BY RCF3) + (ULTRASOUND UNITS MULTIPLIED BY RCF4)			R XXXX,XX	
Derived from				
CODE	DESCRIPTION	AVERAGE TIME	PERCENTAGE USED	TOTAL UNITS
0151	Risk assessment	n/a	100%	16 consultation units
0147	Unscheduled consultation	n/a	97%	13,58 consultation units
0023	Anaesthetic. time	33 minutes	100%	6 anaesthetic units
2614	Labour Epidural	n/a	100%	6 anaesthetic units
0018	BMI > 35	33 minutes	8%	0,24 anaesthetic units
1221	Professional fee PCA	n/a	100%	30 clinical units
0011	Unscheduled time	33 minutes	97%	23,28 clinical units

Code AN2615 – Caesarean Section

	units	own ultrasound	hospital ultrasound
Consultation units	20,48	20,48 X RCF1	20,48 X RCF1
Anaesthetic units	14,4	14,4 X RCF2	14,4 X RCF2
Clinical units	26,58	26,58 X RCF3	26,58 X RCF3
Ultrasound units	variable	15 X RCF4	9,9 X RCF4
Anaesthetic clinic visit required(optional)	39	39 X RCF1	39 X RCF1
Administrative requirements (optional)	9	9 X RCF1	9 X RCF1
Postoperative follow up required (optional)	15	15 X RCF1	15 X RCF1
Own equipment hire (optional code 0007))	15	15 X RCF3	15 X RCF3
EVENT BASED FEE = (CONSULTATION UNITS MULTIPLIED BY RCF1) + (ANAESTHETIC UNITS MULTIPLIED BY RCF2) + (CLINICAL UNITS MULTIPLIED BY RCF3) + (ULTRASOUND UNITS MULTIPLIED BY RCF4)		R XXXX,XX	R XXXX,XX

Derived From

CODE	DESCRIPTION	AVERAGE TIME	PERCENTAGE USED	TOTAL UNITS
0151	Risk assessment	n/a	100%	16 consultation units
0147	Unscheduled consultation	n/a	32%	4,48 consultation units
0023	Anaesthetic. time	51 minutes	100%	8 anaesthetic units
2615	Caesarean section	n/a	100%	6 anaesthetic units
0018	BMI > 35	51 minutes	10%	0,4 anaesthetic units
2800	First TAP/Rectus Block	n/a	30%	10,8 clinical units
2800	Second TAP/Rectus Block (0005)	n/a	30%	8,1 clinical units
0011	Unscheduled time	51 minutes	32%	7,68 clinical units
5103	Ultrasound (own equipment) OR Ultrasound (hospital equipment)	n/a	30%	15 ultrasound units OR 9,9 ultrasound units

Annexure 5 Global Fee Member Advisory



GLOBAL FEE 3rd Advisory

29th March 2017

Dear Member

NON PARTICIPATION IN GLOBAL FEE PRODUCTS AND DISCOVERY ARTHROPLASTY NETWORK

(PLEASE SEE PAGE 2 FOR PRACTICAL APPLICATION OF THIS ADVISORY)

As from the 1st of April 2017, Discovery Health has unilaterally imposed a requirement on its members that they will only be able to receive treatment in the hip and knee arthroplasty (replacement) space from their "Arthroplasty network". Other Administrators and Schemes have introduced other "networks" or global fee products that have similar requirements and include Ophthalmology, Urology and other speciality interventions. Patients who wish to be treated by their chosen surgical specialist and/ or anaesthesiologist who have not signed into a scheme or administrator designed network will be required to make a co-payment to the facility upon admission in some cases in excess of R20 000.

As you will be aware the PPBU has engaged with Discovery Health and other administrators, schemes and third parties regarding these networks, funding models and products since the publication of our Position Statement on ARMs in June 2015. The SASA and South African Orthopaedics Association (SAOA) and other societies are aligned and agree that funding of arthroplasty and other surgical interventions can and should be changed to contain healthcare costs and ensure patients receive the best treatment from the specialists and clinics.

The SASA and the SAOA have expressed concern and objected to the manner in which administrators and funders have embarked upon establishing these networks. The reasons for this include:

1. Unethical contracts being proposed by the intermediaries (clinic groups and third parties) to our members (in contravention of the ethical rules of the Health Professions Council of South Africa - HPCSA).
2. Contracts that are, in our opinion, in contravention of the Consumer Protection Act, the Competitions Act and the constitution of the Republic of South Africa.
3. A direct threat to clinical autonomy as a result of these products that would compromise patient safety and care.
4. A principled stance that any of these introduced networks should not add increased layers of administrative burden and importantly costs - already funded by scheme members.

On the basis of the above, the professionals entrusted to deliver your care are unable to engage in an ethical, regulatory and legally compliant manner.

Please find attached the following correspondence sent out today:

1. Discovery Health correspondence formally indicating the SASA PPBU stance as well as the ramifications of their rollout of their Arthroplasty Network.
2. Facility group correspondence indicating the SASA PPBU stance as well as proposed actions they are empowered to embark on with the rollout of the network.
3. A patient letter available to membership in the event a patient requires explanation with respect to any global fee network product that you have chosen not to engage in at this

PRACTICAL ADVICE WHILE NOT ABLE TO PARTICIPATE IN GLOBAL FEE PRODUCTS

Our advice as at this time is:

1. DO NOT SIGN ANY CONTRACT.
2. This advice is in respect of all global fee contracts including Ophthalmology and Arthroplasty products.
3. Members remain enabled to continue to provide services to Discovery members (or any scheme member/ "global fee patient") within a fixed fee arrangement they agree with, with the patient, and in line with best practice in terms of clinical and financial consent.
4. Provide patients with the attached letter to enable their understanding of the SASA PPBU and your stance that enables them to pursue a remedy for non-reimbursement or co-payment requirement from their chosen funder.

SASA PPBU further guidance on such patient interaction includes:

- Informed consent (as per SASA practice guidelines as well as the SASA coding guidelines) must be obtained including your uniquely determined fee.
- This fee may be a fixed fee (a fixed amount acceptable to you and quoted to the patient up front) and must be disclosed to the patient as part of the consent procedure.
- Ensure understanding that the contractual arrangement for payment remains between you and the patient.
- Provide an invoice as usual to the patient post delivery of services.
- Explain that the patient should seek reimbursement from their funder who remains responsible to them for funding.

Annexure 6 Global Fee Patient Notice



GLOBAL FEE Patient Notice

12th April 2017

Dear Patient

Some Administrators and Schemes have over the past years unilaterally introduced **“networks” or global fee products** based primarily on costs. These networks include hip and knee arthroplasty (replacements eg: ICPS), Ophthalmology (eye care – eg: OMG or ORM for cataract surgery), Urology and other speciality interventions.

These administrators and funders enforce **these “networks”** and while labelled **“specialist networks” that result in “better patient care and outcomes”, they** have not in any way been proven as such in the South African Private Healthcare Sector. They are designed primarily to limit costs. Patients who wish to be treated by their chosen surgical specialist and/ or anaesthesiologist who have not signed into the designed network are often required to make a co-payment to the facility.

The South African Society of Anaesthesiologists (SASA) has engaged stakeholders since June 2015 on strategies to contain healthcare costs and ensure patients receive the best treatment from the specialists and clinics. The interest of you, the patient, is and should be, paramount. SASA is committed to your welfare and your rights as a patient. As these contracts are considered unethical and illegal by many experts and professional associations, our members – your anaesthesiologists – are unable to participate.

A refusal to fund your surgery at all, or to not fully fund your surgery if the total amount is less than that of the global fee or less than your benefits per plan type, or to impose a punitive co-pay, constitutes a violation of law and ethics.

We would therefore encourage you to report such refusal to the Council for Medical Schemes (www.medicalschemes.com, or email: complaints@medicalschemes.com).

Our main concern remains you, the patient, and our ability to work free from undue influence, and in line with legal and ethical prescripts.

Should you have any queries or need any assistance, please direct correspondence to the SASA secretariat at sasa@sasaweb.com or request your specialist Anaesthesiologist, Orthopaedic Surgeon or other Specialist to assist you through their respective societies.

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