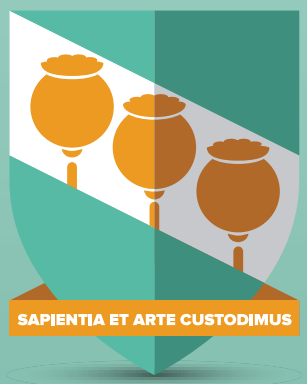
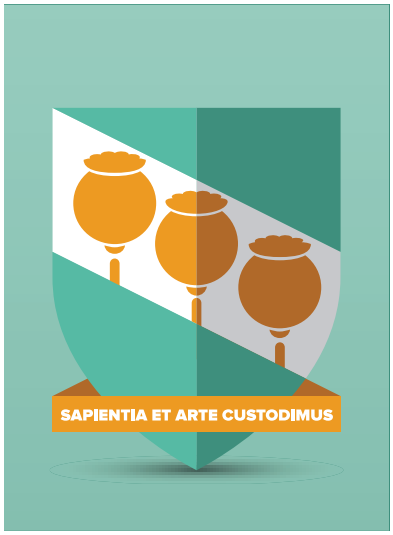



# SASA

SOUTH AFRICAN SOCIETY OF ANAESTHESIOLOGISTS

# Private Practice & Coding Guidelines

# 2021




## SOUTH AFRICAN SOCIETY OF ANAESTHESIOLOGISTS (SASA)

# Acknowledgements

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# Contents

# Private Practice & Coding Guidelines

## 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 private practice members to engage in a fair and transparent manner with 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 South African Society of Anaesthesiologists (hereafter referred to as "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 of September 2021 are:

- 1.4.1 The South African Medical Association Medical Doctors' Coding Manual (MDCM and eMDCM). Members are strongly encouraged to cross reference the guidelines with the most recent edition of the MDCM.
- 1.4.2 The South African Society of Anaesthesiologists Private Practice and Coding Guideline 2019
- 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 Overservicing, 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 68 of 2008: Chapter 2 – Fundamental Consumer Rights
- 1.4.9 Medical Schemes Act 131 of 1989
- 1.4.10 Medical Schemes Amendment Act 62 of 2002: Section 59
- 1.4.11 The Protection of Personal Information Act 4 of 2013 (POPI Act)
- 1.4.12 The Competition Act 89 of 1998

1.5 Sections 2 to 7 deal with the ethical communication and contracting with patients/guarantors.

1.6 Sections 8 to 28 deal with ethical coding practice and are intended to guide members in the appropriate, reasonable and ethical use of codes when providing an invoice for their services to patients. If the Society receives a billing-related complaint, this guideline will be utilised as the basic source document for evaluation thereof. The responsibility for the implementation of correct and ethical coding rests exclusively with the individual practitioner delivering the service.

1.7 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 surgeon's consultation rooms, phone call, text message, or e-mail. It is recommended that members set up an informative and regularly updated website to which patients may be referred via an SMS or e-mail link. Members must ensure that every reasonable effort is made to enable the patient to communicate directly with the member pre- and postoperatively, should the patient have any queries.

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 anaesthetist (See Annexure 1), and the practice billing policy (See Annexure 1).

2.3 It is recommended that the patient/guardian/guarantor have an opportunity to request a cost estimate in Rand value for the planned procedure (See Annexure 1).

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 procedure.

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. These should be stratified, with emphasis placed on most common and most severe for ease of reference for patients.

3.6 Should members intend to utilise patient data for reasons other than the provision of the services, the POPI Act requires specific consent from the patient for this prior to such use of the data. This does not include consent for the sharing of clinical data with the team providing the care, or consent for the submission of invoices to medical schemes, as this information is specifically included in data use for the provision of the services. It is still recommended that practitioners make this information sharing explicitly known to patients. If, however, any other information sharing is considered, specific additional consent is required. This may include clinical information shared with medical schemes for audit purposes, research or the provision of clinical information to family members.

## 4. Contractual principles

4.1 The Society regards the only legally binding contract for the payment of professional fees as that which exists between the anaesthesia service provider and the patient/guardian to whom the service is delivered.

4.2 That contract supersedes any other contractual relationship the anaesthesia 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 (CMS), as a bona fide Medical Scheme or registered Managed Care Organisation.

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 practice and the ability to ensure ethical clinical practice in accordance with the guidelines and regulations of the Health Professions Council of South Africa (HPCSA).

4.5 The Society regards some business practices as unethical and will not provide support to members who enter into such arrangements. **The Society may, in certain circumstances, be obliged to report a breach of the Ethical Rules of the HPCSA to the relevant authorities.** Unethical business practice include:

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 interests.

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 and/or avoid the use of certain drugs and/or methods and/or equipment and/or facilities and whose use of or avoidance of may be to the detriment of the patient.

4.5.4 A contractual agreement between a medical practitioner of another discipline and the member.

4.5.5 A contractual agreement with a third party who acts on behalf of a funder/s or patient and who derives financial gain from the member delivering a professional service to the patient, and who is not duly registered as a Managed Care Organisation with the CMS.

4.5.6 A formal or informal contractual agreement of employment with a specific hospital or hospital group for the rendering of professional services, unless specifically approved and permitted by the HPCSA.

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 interests of the patient, thereby contravening the specific HPCSA rules relating to ethical ownership of shares in a healthcare facility by a healthcare practitioner.

## 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 their individual 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 from this standard tariff 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 anaesthetist

6.1 Members should use a standardised contract form stating the following at minimum (See Annexure 1):

6.1.1 The patient remains responsible for payment of the account.

6.1.2 The patient may nominate a "person responsible for payment of the account as the guarantor, who is aware of this responsibility."

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 the person responsible for payment.

6.1.5 Signature of person responsible for payment – please note that witness signatures are not required.

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.

6.1.9 Intentional consent from the patient/guardian authorising the healthcare practitioner to share relevant clinical information with other involved healthcare practitioners and the patient's designated guarantor or third-party funder.

6.1.10 Intentional consent from the patient/guardian for the sharing of any information outside of the provision of service to the patient, such as research.

## 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 1)

7.2 The billing policy must contain at a minimum (See Annexure 1):

7.2.1 A statement declaring which coding authority is used in determining coding.

7.2.2 An explanation of the method by which professional tariffs are determined by the practice.

7.2.3 An indication of the standard tariff of the practice and preferably a comparison with the tariff offered by major funders.

7.2.4 A statement that the final responsibility for settling the account remains that of the patient/guardian.

7.2.5 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.

7.2.6 A complaints management process with the relevant contact information. This may include a practical dispute resolution process. It is recommended that mediation be suggested as an option to resolve such potential disputes.

## 8. Coding principles

8.1 Anaesthesia services are coded and billed according to the method as described in the South African Medical Association Medical Doctors' Coding Manual (2021).

8.2 When the anaesthetist, other than the medical practitioner performing the procedure, provides anaesthesia services as specified in these guidelines (sedation or otherwise), the anaesthesia codes should be reported.

8.3 Standard anaesthesia services may include, but are not limited to, general anaesthesia, regional anaesthesia, sedation, the supplementation of local anaesthesia, or other supportive services to provide the patient with the anaesthesia care deemed optimal by the anaesthetist 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, standard monitoring (e.g., ECG, temperature, blood pressure, pulse oximetry, regional oxygen saturation and capnography) and procedures necessary to provide safe anaesthetic care (airway management, peripheral venous access, blood gas analysis, nasogastric or orogastric intubation if necessary specifically for the anaesthetic care). Central venous and Swan-Ganz catheter insertion, intra-arterial cannulation, nerve blocks, use of ultrasound, nasogastric or orogastric intubation if specifically indicated to aid the surgical procedure (refer 21.10), and specialised techniques of airway management like fibre-optic intubation, bronchoscopy, and one lung ventilation are not regarded as standard anaesthesia services and must therefore be coded for separately.

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 calculated are added according to the actual time spent providing the anaesthesia service.

8.7 Modifiers 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 perioperative 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 can be billed in addition, provided ownership of the device can be demonstrated. Should the facility in which the member is operating such equipment be able to provide the same or equivalent equipment for use, the member may not bill for the use of their own equipment in such a scenario.

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. To avoid confusion during the billing process, consultation with all other involved practitioners are advised.

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 the base unit value (only one procedure code 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/MDCM). This includes the value of most anaesthesia services except for the time spent in anaesthesia care plus any modifiers.

9.3 The anaesthetic fee is 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 code unit.

9.4 There are four separate RCFs: one each for anaesthetic, consultation, clinical and ultrasound units, each with its own value.

9.5 The calculation of the total fee = (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 + modifier units. See example below.

**Note:** the RCF values quoted are for illustrative purposes only and actual values will vary according to the billing policy of the anaesthesiologist.

| Classification | Description | Code | Unit | Calculation | Sum |
|---|---|---|---|---|---|
| Consultation units | Preoperative risk assessment | 0151 | 16 | 16 X R20.00 (RCF1) | R320.00 |
| Anaesthetic units | Fracture: radius or ulna | 0391 | 3 | 3 X R100.00 (RCF2) | R300.00 |
| | Musculoskeletal modifier | 5441 | 1 | 1 X R100.00 (RCF2) | R100.00 |
| | Anaesthetic time X 49 minutes | 0023 | 8 | 8 X R100.00 (RCF2) | R800.00 |
| Clinical units | Peripheral nerve block | 2802 | 25 | 25 X R15.00 (RCF3) | R375.00 |
| Ultrasound units | Ultrasound soft tissue | 5103 | 50 | 50 X R10.00 (RCF4) | R500.00 |
| | | | | **Total fee** | **R2 395.00** |

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** – This 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 | Preoperative 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 unit value has two components:

10.2.1 The first component reflects all usual services included in the anaesthesia service. Usual services include, but are not strictly limited to, 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 unit value for an anaesthesia service associated with an intrathoracic coronary artery bypass graft (CABG) 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 is allowed for all procedures of the **head, neck or shoulder girdle**, requiring surgical field avoidance and therefore increasing risk. This modifier is added to all procedures code with 4 or less unit values. See example below.

| Classification | Description | Code | Units |
|---|---|---|---|
| Consultation units | Preoperative 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. In Trendelenburg and reverse Trendelenburg positions, the patient is still in the supine position on the theatre bed and these positions are therefore not included in 0032. See example below.

| Classification | Description | Code | Units |
|---|---|---|---|
| Consultation units | Preoperative 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 highest value code (in this case code 1807) is costed in the account. See example below.

| Classification | Description | Code | Units |
|---|---|---|---|
| Consultation units | Preoperative 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 anaesthetist units. This modifier is added to all procedure codes with a value less than 15.00 anaesthetic units. See example below.

| Classification | Description | Code | Units |
|---|---|---|---|
| Consultation units | Preoperative 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 | Preoperative risk assessment | 0151 | 16 |
| Anaesthetic units | Cholecystectomy | 1761 | 6 |
| | Laparoscopic procedure | 1807 | 0 |
| | Anaesthetic time X 49 minutes | 0023 | 8 |

10.4 **2313** – Examination under anaesthesia when no other procedures are performed, not gender specific. 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 complication, necessitating abandonment of the planned procedure. The patient is 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 (0151), in-hospital consultation codes (0109) and all 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 or intraoperative gastric decompression to improve surgical visualisation), 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 performance of fibre-optic intubation.

10.5.4 Use of special equipment owned by the anaesthetist, e.g., an ultrasound machines, 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.

## 11. Consultation services

11.1 **0151 and 0152 and 0153 –** Preoperative assessment. This is face-to-face time spent with the patient, assessing prior medical and surgical history, medication and allergic history, prior anaesthetics procedures, clinical examination and discussion of anaesthetic techniques and risk, requests for appropriate investigations and ordering of any preoperative 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 special circumstances, it is not always possible to see the patient in the ward. Wherever possible, however, this visit should be performed in the ward or an area that affords the patient optimal privacy for such an examination, discussion and the obtaining of consent.

| Preoperative assessment | Duration of consultation | Complexity | Units |
|---|---|---|---|
| 0151 | 10–20 minutes | Simple | 16 |
| 0152 | 20–35 minutes | Simple | 30 |
| 0153 | 30–45 minutes | Moderate | 45 |

11.2 If the preoperative 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.

11.2.1 **0173** – 15 consultation units. First hospital consultation/visit of an average duration and/or complexity. Includes counselling with the patient and/or family and coordination with other healthcare providers or liaison with third parties on behalf of the patient.

11.2.2 **0174** – 30 consultation units. First hospital consultation/visit of a moderately above average duration and/or complexity.

11.2.3 **0175** – 45 consultation units. First hospital consultation/visit of long duration and/or high complexity.

11.3 Emergency consultation services, AT HOME or IN 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). All anaesthesia provided in a theatre environment or operating suite is considered AWAY from home or rooms and should be reported for as code **0147** when meeting emergency consultation criteria. Medical funders do not recognise code **0146** when associated with anaesthesia services provided AWAY from home or rooms.

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 special motivations for procedures and treatment (includes report on the clinical condition of a patient) are 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, 0192** or **0193** (See Section 11.4) as most patients requiring a preoperative consultation with an anaesthetist will have major comorbidities and/or are scheduled for a major surgical intervention.

12.2 Should it be required of the anaesthetist to write a report on behalf of a third-party funder concerning the patient's fitness for the scheduled procedure, it would be appropriate to add code **0133**. 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 anaesthetist 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 with/without 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 anaesthetist 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 anaesthetist 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 anaesthetist 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 the 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 16.1) 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 16.2) or **1208** (See Section 16.6) may be used additionally.

13.3 Time ends when the personal attendance of the anaesthetist is no longer required, and the patient can be safely handed over in the post-anaesthesia recovery unit to appropriately trained nursing or other personnel.

**TABLE I:** Unit breakdown of anaesthetic time

| Anaesthetic time | Units (0023) | Unit increments |
|---|---|---|
| 1–15 minutes | 2 | 2 anaesthetic units per 15-minute intervals for the first 60 minutes |
| 16–30 minutes | 4 | |
| 31–45 minutes | 6 | |
| 46–60 minutes | 8 | |
| 61–75 minutes | 11 | 3 anaesthetic units per 15-minute intervals after 60 minutes |
| 76–90 minutes | 14 | |
| 91–105 minutes | 17 | |
| 106–120 minutes | 20 | |
| 121–135 minutes | 23 | |
| 136–150 minutes | 26 | |
| 151–165 minutes | 29 | |
| 166–180 minutes | 32 | |
| 181–195 minutes | 35 | |
| 196–210 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, after that 3 anaesthetic units are allocated per each 15-minute period or part thereof. (See Table I)

## 14. Emergency anaesthesia services code 0011

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 II).

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 | Preoperative 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 procedure X 49 minutes | 0011 | 24 |

**TABLE II:** Unit breakdown of unscheduled/emergency time

| Emergency anaesthetic time | Units (0011) | Increments |
|---|---|---|
| 1–30 minutes | 12 | 12 clinical units per 30 minutes |
| 31–60 minutes | 24 | |
| 61–90 minutes | 36 | |
| 91–120 minutes | 48 | |
| 121–150 minutes | 60 | |
| 151–180 minutes | 72 | |
| 181–210 minutes | 84 | |
| 211–240 minutes | 96 | |
| 241–270 minutes | 108 | |
| 271–300 minutes | 120 | |
| 301–330 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 (6–8 time units).

| Classification | Description | Code | Units |
|---|---|---|---|
| Consultation units | Preoperative 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 procedure X 45 minutes | 0011 | 24 |
| | Management: patient-controlled analgesic pump | 1221 | 30 |

15.1.3 It is appropriate to code for emergency time (**0011**) if the epidural cannot be postponed, in line with best practice guidelines.

15.1.4 An indwelling epidural catheter inserted during a labour epidural is regarded as standard practice, and therefore, the use of code **2804** (See Section 22.8) 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 section or spinal for caesarean section (**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 anaesthetic code reporting as if a separate procedure.

15.3 **Epidural labour** patients progressing to caesarean section or spinal for caesarean section (**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 anaesthetic code reporting 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 and invasive or active monitoring and intervention thereof, 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 27.3). At full term, she weighs 90 kg (BMI 35.1). 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. **Postoperative assessment and management** (hospital follow up consultation): Anaesthesiology does not have a global fee component, and therefore, if cardiorespiratory, pain or any other assessment or intervention is necessary, this code will apply. It is not appropriate to use code 0109 for a routine postoperative visit where no active management decisions or actions are required.

16.2 **1204** – 30 clinical units. **ICU category 1**: Where the anaesthetist is responsible for intensively monitoring a patient without active intervention. The code may be used once per calendar day and only by one clinician per 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 anaesthetist 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 anaesthetist 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 anaesthetist is the primary physician responsible for a patient.

16.6 **1208** – 137 clinical units. **ICU category 2** patient who 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 anaesthetist 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 anaesthetist 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 anaesthetist to transport the patient to ICU, as well as setting up the ventilation, infusions, etc. He/she is also responsible for pain management and sedation.

**SUGGESTION:** The primary practitioner should use codes 1205/1206/1208. In this case, the anaesthetist 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 anaesthetist 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** – 75 clinical units. **ICU ventilation: First 24 hours**. May only be used if the anaesthetist is the primary physician responsible for the ventilation of the patient.

16.10 **1213** – 50 clinical units. **ICU ventilation: Subsequent days, per calendar day**. May only be used if the anaesthetist is the primary physician responsible for the ventilation of the patient.

16.11 **1214** – 25 clinical units. **ICU ventilation: After 2 weeks, per calendar day**. May only be used if the anaesthetist is the primary physician responsible for the ventilation of the patient.

16.12 **1321** – 30 clinical units. Stand-by fee for **coronary angioplasty**. Anaesthetist 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. **Cardiopulmonary 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** intraoperatively, 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** – Cardiopulmonary 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. An alternative is to code for the applicable ICU support codes (**1205**, **1208** or **1209**) and necessary additional procedures.

**Rule R**

In the case of ICU category 3 patients, the units for codes **1208**, **1209** and **1210** include code **1211** (cardiorespiratory 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 (repositioning 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 III). 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 III:** Unit breakdown of blood pressure control time

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

| Appropriate use of blood pressure control (0039) includes (but is not limited to): | |
|---|---|
| **Improved surgical exposure**<br>• mastoidectomy<br>• tympanoplasty<br>• spinal surgery<br>• major neck dissections<br>• endoscopic sinus drainage<br>• mandibular or maxillary osteotomy<br>• total hip replacement<br>• total shoulder replacement | **Maintain perfusion pressures**<br>• shoulder surgery (any surgery where extreme positioning places vital organs at risk)<br>• cardiac surgery<br>• craniotomy for tumour/aneurysm<br>• major vascular surgery<br>• carotid endarterectomy<br>• major plastic free flaps<br>• vasoactive tumours – pheochromocytoma/carcinoid syndromes<br>• pre-eclamptic or eclamptic patients<br>• major organ transplantation (liver/kidney/heart/lung)<br>• liver resection<br>• shocked trauma cases on inotropic support<br>• 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 cardiopulmonary bypass cases where a heat exchanger is used as well as where deep hypothermic arrest is employed.

17.4 **0038** – **Perioperative blood salvage**: Add 4 anaesthetic units for intraoperative blood salvage and 4 anaesthetic units for postoperative blood salvage. Perioperative blood salvage is appropriate for the collection of autologous blood intraoperatively and for the administering of salvaged blood (either from cell-saver or re-infusion drains) in the postoperative 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 for surgery on neonates up to and including 28 days after birth **or** low birth weight infants (less than 2 500 g) under general anaesthesia (**excluding circumcision**). There is a 50% increase in anaesthetic time units for the anaesthetist. 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. This code may be used in addition to 0044, if applicable.

**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 2 300 g.

**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 2 500 g. 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 | Preoperative 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 X 100 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 **body mass index (BMI) of 35 or greater** (calculated according to kg/m$^2$): A 50% increase in anaesthetic time units only for anaesthetists. The patient's weight, height and BMI must be indicated on the account if the code 0018 is used. See example below.

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

E.g., if a patient has a BMI of 35.09, he/she would not qualify for the use of 0018, but a BMI of 35.1 would qualify. Some funders would only calculate the rounded whole number, resulting in a BMI of 35, which disqualifies the use of 0018, and is incorrect.
It is NOT appropriate to use code 0018 when performing standalone procedures, e.g., insertion of dialysis lines, or for procedures performed under anaesthesia, e.g., insertion of an arterial line.
It is NOT appropriate to use code 0018 with ICU codes, ventilation codes and codes 1321, 1112 and 1120 (see Sections 16.2 to 16.14)
It is appropriate to use code 0018 with the performance of a labour epidural in a patient that qualifies.

| Classification | Description | Code | Units |
|---|---|---|---|
| Consultation units | Preoperative risk assessment | 0151 | 16 |
| Anaesthetic units | Fracture: metacarpal – ORIF | 0406 | 3 |
| | Musculoskeletal modifier | 5441 | 1 |
| | Anaesthetic time X 49 minutes | 0023 | 8 |
| | BMI = 35.4 (50% of 0023) | 0018 | 4 |

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
- 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 with shortness 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 causing 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
- acute respiratory distress syndrome (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 an "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 temporomandibular** 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 | Preoperative 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 procedure X 49 minutes | 0011 | 24 |

# 21. Procedures performed by the anaesthetist

21.1 It is appropriate for anaesthetists 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 an unscheduled patient 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**. 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 | Emergency 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 anaesthetist 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 anaesthetist if they are **not** the attending doctor either in the ICU/high care or involved in the pre- and intraoperative 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 anaesthetist 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 anaesthetist passes an oesophageal dilator.

21.11 **0113** – 45 clinical units. **Newborn attendance**: Emergency attendance to newborn 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 anaesthetist.

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

21.13 **3637** – 78 ultrasound units. **Trans-oesophageal echocardiography + colour Doppler.** May not be added to 3636 (Cardiac ultrasound examinations). Only applicable to diagnostic vascular scan of the femoral or carotid arteries. Not applicable to be used with 5103 if the sole purpose of ultrasound use is for the placement of CVP, arterial or dialysis lines or nerve blocks.

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 **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 (IABP)**: Where an anaesthetist would be responsible for **operating** an IABP. Appropriate as a once–off charge if the anaesthetist 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 IABP** (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 IABP, 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 laryngoscop**y: Diagnostic laryngoscopy including biopsy (also to be applied when a flexible fibre-optic laryngoscope was used). Appropriate to be used by the anaesthetist if a **fibre-optic intubation** was performed. It is **not** appropriate to use code 1130 for the use of a non-flexible laryngoscope with fibre-optic technology or indirect visualisation technology (Videolaryngoscopes).

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 postoperative pain management provided by the anaesthetist and/or surgeon is included in the global fee for the surgical procedure. Routine postoperative pain management includes oral, intramuscular, or intravenous medications.

22.2 Some procedures and/or patients require additional postoperative pain management, and this is frequently provided or supervised by an anaesthetist. 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 IV).

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

**TABLE IV:** Classification of nerve and neuraxial blocks by coding

| 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 | | | |
| Fascia 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 Where multiple nerve blocks are performed on the same patient during the same anaesthetic, only two blocks may be coded for, provided that the second block is in a different anatomical area from the first (see example below). **Modifier 0005 is not applicable** to pain blocks. See example below.

Explanatory notes on multiple procedures for pain relief
- Performing a wrist block which requires at least three injections is not regarded as multiple blocks as one anatomical area is blocked.
- Doing bilateral rectus sheath blocks are regarded as two separate blocks as two anatomical areas (left and right) are being anaesthetised.

| Classification | Description | Code | Units |
|---|---|---|---|
| Consultation units | Preoperative 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) | 2800 | 36 |
| 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 procedure (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 coded for and the coding should be as for a general anaesthetic.
- If an epidural is inserted for postoperative pain relief, then **2801**, **2804** and **1221** (if appropriate) may be used. (Note, for a labour epidural (**2614**) code **2804 is omitted**. See 15.1.4)
- 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 anaesthetist.

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 (e.g., 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 care

23.1 Monitored anaesthesia care is defined as instances where an anaesthetist 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 anaesthetist is required to provide preoperative assessment, to remain in attendance during the procedure to monitor the patient and to administer additional anaesthesia/drugs and/or provide postoperative services should it be required.

23.2 The procedure should be assigned the applicable 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 anaesthetist to be present in the operating room to monitor vital signs and manage the patient, 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 may respond purposefully and variably to verbal commands, either alone or by light tactile stimulation. A distinction is also made between light sedation and deep sedation.

24.2 During light sedation, the patient responds to verbal or tactile stimuli, airway intervention may/may not be required, spontaneous ventilation is adequate and unsupported, and the cardiovascular function is managed adequately.

24.3 During deep sedation, purposeful response is only after repeated or painful stimuli, airway intervention or support may be required, spontaneous ventilation may be inadequate and cardiovascular function is maintained.

24.4 Sedation is therefore seen as an anaesthetic technique. According to an 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 is provided, a second appropriately qualified practitioner had to be present to independently monitor the patient during the sedation period and for their recovery.

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 an anaesthetist (not the operator): The account is rendered as for general anaesthesia. Sedation is an anaesthetic technique that should be performed utilising the same basic standards of care as is required for a general anaesthetic.

24.7 **0020** – No unit value (descriptor only). This code may be used on the anaesthetic account to indicate that the procedure was performed in an unattached theatre suite or procedure room 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 is coded only once).

25.1.3 If the equivalent and fully functional equipment in question is available for the anaesthetist's use within the facility where the service is being delivered, it is not considered appropriate to code for 0007, even if own equipment is used.

**SCENARIO:** An anaesthetist 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 rented out for patient use. Code 1220 is appropriate in these cases (See Section 22.9).

25.1.5 Rule 0007 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 anaesthetist 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 was used. See example below.

**SCENARIO:** Anaesthetist A (hospital A) and anaesthetist 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 anaesthetists own their own ultrasound equipment.

**SUGGESTION:** 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 | Emergency 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 anaesthetist code

26.1 When it is necessary to have a second anaesthetist, it would be appropriate to use code **0029**. The time unit value for the second anaesthetist shall be the same value for the first hour, and thereafter at 80% of the principal anaesthetist'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 anaesthetist.

26.3 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 anaesthetist.

26.4 Any intraoperative procedure performed by the assistant (e.g., an ultrasound for regional anaesthesia – 5103) is coded by the anaesthetist who performs the procedure.

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

26.6 Code 0029 and its corresponding values must be submitted within the same account as that of the primary anaesthetist.

**Example assistant anaesthetist**

| Classification | Description | Code | Units |
|---|---|---|---|
| Consultation units | Preoperative risk assessment | 151 | 16 |
| Anaesthetic units | Partial gastrectomy | 1617 | 7 |
| | Anaesthetic time × 154 minutes | 0023 | 29 |
| | **Assistant 0023** | 0029 | (7 + 29) × 80% = 28.8 |
| | Body mass index | 0018 | 29/2 = 14.5 |
| | **Assistant 0018** | 0029 | 14.5 × 80% = 11.6 |

## 27. General practitioner anaesthetist

27.1 **0036** – Anaesthesia administered by general practitioner/diplomate anaesthetist. For anaesthesia lasting 1 hour or less, the units (basic units + 0023 + modifiers) is the same as for a specialist anaesthesiologist.

27.2 For anaesthesia lasting more than 1 hour, the units (basic units + 0023 + modifiers) is calculated at 4/5 (80%) of the total applicable to the specialist anaesthetist.

27.3 This reduction does not apply to procedures/ultrasound performed by the practitioner (i.e. 1215, 1218, 1221, 1780, 2800, 2801, 2802, 5103, etc.).

**Less than 60 minutes**

| Classification | Description | Code | Units |
|---|---|---|---|
| Consultation units | Preoperative risk assessment | 0151 | 16 |
| Anaesthetic units | Appendicectomy | 1675 | 4 |
| | Anaesthetic time × 49 minutes | 0023 | 8 |
| Clinical units | 49 minutes | 0011 | 24 |

**More than 60 minutes**

| Classification | Description | Code | Units |
|---|---|---|---|
| Consultation units | Preoperative risk assessment | 0151 | 16 |
| Anaesthetic units | Appendicectomy (4 × 0.8) | 1675 | 3.2 |
| | Anaesthetic time × 100 minutes (17 × 0.8) | 0023 | 13.6 |
| Clinical units | 100 minutes (48 × 0.8) | 0011 | 38.4 |

27.4 Medical aid administrators would automatically recognise the practice number of a general practitioner anaesthetist, and it should be unnecessary to specifically report code 0036.

## 28. Chronic pain management services

28.1 Chronic pain management services are not anaesthesia services. These are distinct services frequently performed by anaesthetist who have additional training in pain management.

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

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

28.4 Each code for pain management services has a specific fee for the services or procedures rendered. In other words, no adjustments are made based on time, physical status or qualifying circumstances. These codes are similar to those used for nerve blocks during anaesthesia. See Table IV.

28.5 **2789** – 143.80 clinical units. **Destruction by neurolytic agent**.

28.6 **2791** – **discontinued. Refer 2789.**

28.7 **2793** – **discontinued. Refer 2789.**

28.8 **2805** – 35 clinical units. **Alcohol injection in peripheral nerves for pain: Bilateral**.

28.9 **2849** – 20 clinical units. **Sympathetic block: Other levels: Unilateral**. E.g., lumbar sympathetic pain block for complex regional pain syndrome (CRPS).

28.10 **2851** – 35 clinical units. **Sympathetic block: Other levels: Bilateral**.

28.11 **2853** – 20 clinical units. **Sympathetic block: Diagnostic/therapeutic**. May be intercostal/brachial/peripheral or Stellate ganglion.

28.12 **2927** – 320 clinical units. Rhizotomy: Extradural, but intraspinal.

## 29. Guideline to event-based billing (global or fixed fees)

29.1 **Definitions**

29.1.1 **Event-based fee (EBF)** – refers to the fee associated with a specified clinical event per professional service rendered. This fee will include all perioperative services irrespective of modifiers applicable or extra procedures performed to provide the anaesthetic service for the stipulated procedure and should be stipulated in the contract. E.g., the EBF for anaesthesia may be R XXXXXX.XX for an uncomplicated unilateral knee replacement. The EBF is distinguished from global, fixed, or bundled fees by the following:

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

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

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

29.1.2 **Global fee or fixed fee** – may be defined according to the intentions of the describing party, e.g.:

29.1.2.1 Defined as an event-based fee (EBF) (See Section 29.1.1) or

29.1.2.2 Defined as the total expenditure for all professional services associated with a specified clinical event. This type of global fee is usually paid to the "team leader", e.g., the surgeon who 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, owing to the multiple potential infringements, perversities and patient harm that may occur with respect to the ethical rules of the HPCSA, this practice is deemed undesirable by SASA and the HPCSA.

29.1.2.3 Defined as the total expenditure for all clinical services associated with a specified clinical event, including hospitalisation. This type of 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, owing to the multiple potential infringements, perversities and patient harm that may occur with respect to the ethical rules of the HPCSA, this practice is deemed undesirable by SASA and the HPCSA.

29.1.3 **Bundled fee or service** – may be defined according to the intentions of the party describing the global or fixed fee, e.g.:

29.1.3.1 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 who 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, owing to the multiple potential infringements, perversities and patient harm that may occur with respect to the ethical rules of the HPCSA, this practice is deemed undesirable by SASA and the HPCSA.

29.1.3.2 Defined as the total expenditure for all clinical services associated with a specified clinical event, including hospitalisation. This bundled 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, owing to the multiple potential infringements, perversities and patient harm that may occur with respect to the ethical rules of the HPCSA, this practice is deemed undesirable by SASA and the HPCSA.

29.2 **Considerations for determining the value of the event-based fee**

To determine a reasonable, ethical and sustainable professional service tariff for an EBF, each practice should take into account the following guidelines based on a suggested framework with considerations relating to a fee for service environment. Though the guidelines are advisable, they are not enforceable, and each practice should consider the unique environment of their professional service delivery with the inclusion or rejection thereof.

29.2.1 Unique practice data can be utilised to determine the average fee billed for a specific clinical event over a minimum period of the previous twelve months, **OR**

29.2.2 Evaluation or assessment of patients for perioperative fitness done on request, e.g., an anaesthetic clinic consultation, allows for codes 0191 and 0133 to be added to the EBF, or alternatively, be charged separately on agreement.

29.2.3 Clinical reports required by funders and/or administrators allow for code 0133 to be added to the EBF (See Section 11.5) or charged separately on agreement.

29.2.4 The requirement of any postoperative anaesthetic-related services, e.g., follow-up patient visit, allows for code 0109 to be added to the EBF (See Section 16.1) or charged separately on agreement.

29.3 **Reporting of EBF events**

29.3.1 Billing for an EBF event involves the use of a specific code recognisable by funders and the practice administration as such. The following coding convention is recommended by SASA (please note that the EBF event code may differ between funders and between different clinical events:

29.3.2 The capital letters "AN" is added as a prefix to the procedure code to which the EBF event is applicable, e.g., AN0637 for an uncomplicated primary hip replacement and AN2259 for a robotic prostatectomy.

29.3.3 For invoicing purposes, 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 to the clinical event be added to the invoice, with a zero or nominal value, i.e., consultation, time, modifier, clinical or ultrasound codes. See example below (Please note that the codes JBANA1 and JBMOD, as well as the value of the other codes, are specific to the medical scheme administrator and may differ between medical schemes).

29.3.4 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 29.4)

29.3.5 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 inform cost calculations for the following calendar year when the EBF contract value is to be negotiated with the funders by the participating practice.

***INVOICE***

Date : 18 Sep 2018

DH Arthroplasty
Invoice Example for
SASA Event Based Contract
for Discovery Health EBC

Reference : **10732**
Clinic : TEST Clinic
Ref By : TEST Dr
Prac No : 01234567
Med Aid : DH
M A Num : 99999999

Patient : DH Arthroplasty

| Date | CODE | SERVICE | ICD CODE | AMOUNT |
|---|---|---|---|---|
| 01 Sep 2018 | JBANA1 | DH Arthroplasty EBC | M19.05 I10 | XXXXX.XX |
| 01 Sep 2018 | JBMOD | 122 mins (08:00 - 10:02) | M19.05 I10 | 0.10 |
| 01 Sep 2018 | 0151 | Anaes Assessment | M19.05 I10 | 0.10 |
| 01 Sep 2018 | 0637 | Total Hip Replace | M19.05 I10 | 0.10 |
| 01 Sep 2018 | 0023 | Anaes Time: 122 min (08:00 - 10:02) | M19.05 I10 | 0.10 |
| 01 Sep 2018 | 2799 | Spinal Block – post operative pain relief | M19.05 I10 | 0.10 |
| 01 Sep 2018 | 0018 | BMI: 38.67 Wt=99kg; Ht=1.60m | M19.05 I10 | 0.10 |
| 01 Sep 2018 | 1221 | Part Contrl Analgesia | M19.05 I10 | 0.10 |
| 01 Sep 2018 | 5432 | ASA II | M19.05 I10 | 0.10 |
| | | | TOTAL DUE R | XXXXX.XX |

29.4 **Ethical and legal requirements of an EBF contract**

29.4.1 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.

29.4.2 Owing to the multiple potential infringements, perversities and tendency to patient harm inherent in the practice, it is considered undesirable 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.

29.4.3 It is unlawful and contractually unsound 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.

29.4.4 The EBF contract must clearly stipulate that the primary contractual agreement will be between the patient and the medical professional, with professional ethical care superseding any other contractual responsibilities that the two signatories agree to.

29.4.5 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 a sustainable value and 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 29.2.2, 29.2.3 and 29.2.4). Specifically, exploitation of the professional or the patient financially (or their funding mechanism) should be guarded against.

29.4.6 The EBF must be charged for all cases specified for a clinical event irrespective of patient age, physical status, or funder responsible.

29.4.7 The EBF contract must specify to which clinical event/s the contract applies.

29.4.8 Any exclusion criteria applicable to the clinical event/s stipulated in the contract must be clearly defined.

29.4.9 Once surgery has commenced, SASA considers any "carve out" or "exclusion criteria" of patients from an EBF and reversion to fee-for-service for the event unethical. Where a catastrophic medical complication occurs intraoperatively the payment for the arthroplasty event remains at the fixed fee agreed upon. Any additional fees, including ongoing treatment for the complication event, should be funded according to the category of medical aid plan selected by the patient and/or in accordance with statutory benefits.

29.4.10 Clinical responsibility must be clearly defined in the EBF contract, e.g., the anaesthetist will be responsible for a preoperative assessment for fitness for anaesthesia and surgery, with a subsequent report of motivation regarding the anaesthetic fitness of the patient, proposed intraoperative anaesthetic management and 24 hour postoperative care envisaged. The report should be forwarded to the funder/administrator confirming participation in clinical data collection.

29.4.11 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.

29.4.12 It is desirable that the participating anaesthetist provide a specified clinical guideline to his/her team that may be attached as an addendum to the EBF contract or kept as evidence of a current clinical guideline applied by the anaesthetist within his/her operating team.

29.4.13 The relevant professional society is 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 only within the prescripts of the Competition Act 89 of 1998 as amended.

29.4.14 The EBF contract must not contain any incentives to under service or over service a patient.

29.4.15 The monetary value of the EBF must be clearly specified in the contract.

29.4.16 The period of validity of the EBF contract must clearly be stated in the contract.

29.4.17 Annual review of all aspects related to the contract is strongly recommended.

29.4.18 A clearly specified exit procedure must be defined in the EBF contract.

29.5. **The SASA event-based contract** 

29.5.1 SASA has developed the event-based contract (EBC) to address the ethical and legal concerns associated with global and bundled fee arrangements.

29.5.2 The SASA EBC specifically includes and outlines all the relevant principles of ethical care that should be provided to patients and the legal terms of engagement between the patient, funder and/or administrator, and the clinician.

29.5.3 The SASA EBC effectively enables practitioners, on behalf of themselves and patients, to permit meaningful engagement, thereby allowing accountability of all parties to an EBF, including the funder and/or administrator on behalf of the patient, the facility, and fellow professionals.

29.5.4 The EBC is administered, updated, and distributed by SASA. The Society ensures that the EBC is compliant in terms of statutory and legal requirements and in accordance with HPCSA ethical rules.

29.5.5 The EBC consists of two components and is subject to a third condition:

29.5.5.1 The headline contract between the service provider and the specific medical scheme administrator, containing all the terms and conditions governing the relationship between the member and the patient, and the member and the medical scheme administrator. SASA determines, updates, and monitors the content of the headline contract, which is generic and/or similar across all clinical events and medical schemes. It is required that the headline contract be renewed biennially.

29.5.5.2 The "Annexures" specifies the conditions under which the professional services are rendered. It contains applicable information about the contract, regarding clinical events, determination of the EBF, participating medical schemes as well as included clinical conditions (ICD 10 codes). The annexures are designed, updated, and monitored by SASA in terms of structure and content to ensure ethical and legal compliance. The annexures are only then concluded between the clinician and the medical scheme administrator. SASA does not participate and is not privy to agreed-to EBFs between the clinician and funder/administrator. The annexures are to be renewed annually between the funder/administrator and the clinician.

29.5.5.3 An EBC is only enforceable once a current and existing societal contract between the funder/administrator and the clinical service provider has been agreed upon and signed. This SASA – Administrator contract details the requirements of the society to participate in peer review and governs the requirements for both parties to maintain transparency, review viability and success of EBCs and to ensure patient-centered quality care is achieved.

29.5.6 For more information about the SASA EBC, e-mail your enquiry to ppbusasa@sasaweb.com

# ANAESTHESIA FORM NARKOSEVORM

LEES ASSEBLIEF AFDELINGS A, B, C, & D, VUL GEGEWENS IN, TEKEN ONDER EN OORHANDIG AAN DIE NARKOTISEUR.
L.W. AFDELING C MOET INGEVUL WORD DEUR DIE REKENINGPLIGTIGE

PLEASE READ AND COMPLETE SECTIONS A, B, C, & D, SIGN BELOW AND HAND TO THE ANAESTHESIOLOGIST.
N.B.SECTION C. MUST BE COMPLETED BY THE PERSON RESPONSIBLE FOR THE ACCOUNT.

## A OOREENKOMS TUSSEN DIE ANESTESIOLOOG EN PASIËNT / AGREEMENT BETWEEN THE ANAESTHESIOLOGIST AND PATIENT

**PASIËNT:**

**A1.** Ek begryp dat 'n insidentvrye narkose nie gewaarborg kan word nie.
**A2.** Ek begryp dat teatertoerusting en personeel deur die hospitaal verskaf word. Narkosetoerusting word daagliks getoets.
**A3.** Ek onderneem om nie alkohol te gebruik, 'n motorvoertuig te bestuur, sosiale media te gebruik, om die alleen-verantwoordelike te wees vir 'n baba of minderjarige kind, enige gevaarlike toerusting te hanteer, belangrike besluite te neem of dokumente te teken vir 'n tydperk van 24 uur nadat narkose toegedien is nie.
**A4.** Ek verleen toestemming dat my persoonlike inligting bekend gemaak mag word aan belanghebbende instansies, soos deur die wet bepaal, asook anonieme data van 'n kliniese en praktykbesturende aard wat tot die bevordering van die pasiënt se welstand mag bydra.
**A5.** Ek stem toe tot die verwerking van my persoonlike en gesondheidsinligting ten einde behoorlike behandeling aan my te verskaf, en/of vir administratiewe doeleindes deur die betrokke inrigting of professionele praktyk. Hierdie toestemming betrek ook die verantwoordelike partye wat optree as diensverskaffers aan die inrigting of professionele praktyk.
**A6.** In die geval van enige eis, klagte of grief, sal ek voordat ek enige regsaksie neem, gebruik maak van 'n gratis en konfidensiële premediasievergadering met 'n geakkrediteerde bemiddelaar aangewys deur South African Society of Anaesthesiologists (SASA).
**A7.** U narkose rekening is totaal onafhanklik van enige ander rekening wat deur die hospitaal of chirurg uitgereik word.
**A8.** Die koste (beraming) vir die narkose is met my bespreek.
**A9.** Die koste (beraming) soos uiteengesit in deel C is gebasseer op hoe lank die prosedure sal duur , en mag verander weens onvoorsiene omstandighede of onverwagte komplikasies.
**A10.** U is persoonlik verantwoordelik vir betaling van u rekening en nie u mediese fonds nie. U mediese fonds mag dalk nie die hele bedrag dek nie, afhangend van die mediese fonds en die plan opsie wat u gekies het.
**A11.** Sou u rekening oorhandig word vir invordering, sal rente van 2% per maand gehef word op alle agterstallige bedrae. Alle koste verbonde aan die invordering sal van u verhaal word teen prokureur en kliënte skaal.

*Ek het bostaande gelees, begryp en aanvaar die voorwaardes soos uiteengesit. Ek verklaar dat ek by my volle verstand is ten tye van ondertekening en dat ek dit uit vrye wil doen. Hiermee gee ek toestemming vir narkose vir myself of my afhanklike.*

GETEKEN: DATUM:

**PATIENT:**

**A1.** I understand that no one can guarantee an incident free anaesthetic.
**A2.** I understand that the theatre staff and equipment are supplied by the hospital. Anaesthetic equipment is checked on a daily basis.
**A3.** I agree not to drink alcohol, drive a car, utilise social media, be responsible as a sole care provider for infants/small children, operate any dangerous equipment, make important decisions or conclude agreements for 24 hours after recovering from anaesthesia.
**A4.** I agree to allow my personal data to be forwarded to the relevant organisations as required by law and to allow anonymous data of a clinical and practice management nature, to be collected to help to improve the patients healthcare experience.
**A5.** I agree to the processing of my health and personal information in order to provide me with proper treatment, care and/or for the administration of the institution or professional practice concerned. This consent would extend to responsible parties acting as service providers to the institution or professional practice concerned..
**A6.** In the event of any claim, complaint or grievance, I shall prior to taking any legal action, promptly initiate a free and confidential pre-mediation meeting with an accredited mediator appointed by South African Society of Anaesthesiologists (SASA).
**A7.** Your anaesthetic account is rendered completely independently from the accounts rendered by the hospital and the surgeon.
**A8.** The make up of the cost estimate for the anaesthetic service has been discussed with me.
**A9.** The cost estimate as set out in section C is time-based and may change as a result of unforeseen circumstances and unexpected complications.
**A10.** You are personally responsible for payment and not your medical scheme. Your medical scheme may not cover the full amount on your account, depending on the medical scheme and the plan option which you have chosen.
**A11.** Should your account be handed over for collection, interest will be charged at 2% per month on all outstanding amounts. All costs incurred to collect the arrears will be for your account on attorney and client scale.

*I have read, understood and agree to the conditions mentioned above. I declare that I am of sound mind at the time of signing this agreement and that I am not under duress. I hereby give permission for anaesthesia on myself or my dependant.*

SIGNED: DATE:

## B PASIENT VAN : / PATIENT SURNAME : — GEB.DATUM: / BIRTH DATE:

VOLLE VOORNAME : / FIRST NAMES :

## C PERSON RESPONSIBLE FOR ACCOUNT/MAIN MEMBER

| | | |
|---|---|---|
| MEDIESEFONDS : / MED FUND : | OPSIE: / OPTION: | NOMMER : / NUMBER : |
| MAGTIGINGS No : / AUTHORIZATION No : | GAPINGDEKKING: / GAP COVER: | |
| VAN : / SURNAME : | TITEL: / TITLE: | VOORLETTERS : / INITIALS : |
| POSADRES : / POSTAL ADDRESS : | | |
| | | POS KODE : / POSTAL CODE : |
| I.D. No : | | SEL: / CEL: |
| TEL HUIS : / TEL HOME : | TEL WERK : / TEL WORK : | FAKS : / FAX : |
| WOONADRES : / RES. ADDRESS : | WERKGEWER : / EMPLOYER : | |
| | ADRES : / ADDRESS : | |
| | epos: / email: | |
| FAMILIE/VRIEND: / FAMILY/FRIEND: | | |
| TEL: | KOSTE BERAMING: / COST ESTIMATE: | |

FOR MORE INFORMATION VISIT WWW.SASAWEB.COM

Dr. No

HOSPITAAL : VR DATUM:

CHIRURG :

PROSEDURE :

NARKOSETYD : VAN : TOT : MIN

Anaesthesiologist

No

| | | |
|---|---|---|
| 0173 | 0145 | 0146 |
| 0147 | 0151 | |
| KODE : | | |
| | ICD 10 | |
| ASA | 0039 | MIN |
| 543 | 0011 | MIN |

SASA SOUTH AFRICAN SOCIETY OF ANAESTHESIOLOGISTS

**AMPTELIK OFFICIAL**
PLAK HOSPITAAL PLAKKER HIER
PASTE HOSPITAL STICKER HERE

| | |
|---|---|
| 0109 | 544 |
| 0026 | 1204 |
| 0032 | 1215 |
| 0034 | 1218 |
| 0038 | 1220 |
| 0042 | 1221 |
| 0043 | 1780 |
| 0044 | 2800 |
| 0019 | 2801 |
| 0018 | 2802 |
| | 2804 |
| | 5103 |

Disclaimer: 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 jointly 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.

## Anaesthesia Record

SASA

| Date | Height(cm) | Pre-operative airway assessment<br>Mouth opening: Neck extension: | |
|---|---|---|---|
| ASA / Age | Weight(kg) | Fasting Teeth | |

CVS

Resp

Other

☐ Sedation
☐ Regional
☐ General

- ☐ Pre-oxygenation
- ☐ Endotracheal tube size:_____
- ☐ DLT R L Size ____
  Intubation Grade_____
  - ☐ Non-traumatic
  - ☐ Air entry right - left
  - ☐ Rapid sequence induction with cricoid pressure
- ☐ Face mask
- ☐ Laryngeal mask size:

- ☐ Circle circuit
- ☐ Bain circuit

- ☐ Spontaneous breathing
- ☐ Mechanical ventilation
  tidal volume _____ mL
  rate: /minute

- ☐ Eyes taped shut
- ☐ Pressure points padded
- ☐ Warmer
- ☐ Calf Compressors

Intravenous Lines
①size____ site _____
②size____ site _____

**Monitor**
- ☐ ECG
- ☐ BP
- ☐ $SaO_2$
- ☐ Central venous line size: _____ site: _____
- ☐ Arterial line size: ____ site: _____
- ☐ Peripheral nerve simulator
- ☐ Temperature
- ☐ TOE
- ☐ _____

☐ Machine check OK

CPB on / CPB off AXC on / AXC off

| Agent | Dose |
|---|---|
| | |
| Vapour(%) | |
| oxygen/nitrous/Air | |
| Time: | |
| Position: | |
| Heart rate (HR) ● | 200 180 160 140 120 100 80 60 40 |
| Blood pressure Systolic V Diastolic Λ | |
| $O_2$saturation($SaO_2$) | |
| End tidal $CO_2$($ETCO_2$) | |
| Fluids | |
| Infusions: | |
| Urine (mL) | |
| Blood loss (mL) | |
| Temperature (ºC) | |
| CVP | |
| Events: | Input: / Output: |

| Post-Anaesthetic Care Unit | HR: | BP: | RR: | $SaO_2$: | $FIO_2$: |
|---|---|---|---|---|---|
| Start time: | End time: | Anaesthetist | | | |

**D** HAS THE PATIENT HAD THE FOLLOWING / HET DIE PASIËNT DIE VOLGENDE GEHAD

| | YES | NO | DETAILS / BESONDERHEDE |
|---|---|---|---|
| Previous anaesthetics (when, which operation)<br>Vorige narkose ( wanneer, watter operasie) | | | |
| Problems with previous anaesthetics (details)<br>Probleme met vorige narkose (besonderhede) | | | |
| Any family member with anaesthetic problems (what?)<br>Enige familielid met narkose probleme (wat?) | | | |
| Porphyria, malignant hyperthermia or scoline apnoea<br>Porfirie, maligne hipertermie of scoline apnee | | | Weight: Gewig: Kg / Height: Lengte: M |
| Allergy / unusual reaction to medicines (which?)<br>Allergie / vreemde reaksie op medisyne (watter?) | | | |
| Names of all medication, pills, herbal medicine<br>Name van alle medikasie, pille, kruie medisyne | | | |
| Cortisone treatment in the past 12 months<br>Kortisoonbehandeling in die afgelope 12 maande | | | |
| High blood pressure<br>Hoë bloeddruk | | | |
| **Heart diseases (eg. Chest pain, heart attack, rheumatic fever)<br>Hartsiekte (bv. Borskaspyn, hartaanval, rumatiekkoors)** | | | |
| Previous thrombosis / embolism (legs/lungs?)<br>Vorige trombose / embolisme (bene/longe?) | | | |
| What exercise do you do?<br>Watter oefening doen u? | | | |
| Asthma, bronchitis or emphysema<br>Asma, brongitis of emfiseem | | | |
| Recent cold, cough or flu<br>Onlangs verkoue, hoes of griep | | | |
| Heavy snoring / problems sleeping<br>Snork / slaapstoornisse | | | |
| Diabetes or thyroid problems<br>Suikersiekte of skildklier probleem | | | |
| Jaundice or hepatitis (If so, when?)<br>Geelsug of hepatitis (indien wel, wanneer?) | | | |
| Kidney or bladder disease<br>Nier- of blaassiekte | | | |
| Muscle weakness or stroke<br>Spierswakheid of beroerte | | | |
| Tendency to bleed or bruise<br>Bloei of kneus maklik | | | |
| Epileptic convulsions or blackout of any sort<br>Epileptiese aanvalle of floutes van enige soort | | | |
| Are you pregnant/breastfeeding?<br>Is u swanger of borsvoed u tans? | | | |
| False, loose or crowned teeth (if so, where?)<br>Vals, los of gekroonde tande (indien wel, waar?) | | | |
| Alcohol consumption per week<br>Alkohol gebruik per week | | | |
| **Do you smoke or use an E-cigarette? (if so, how many per day?)<br>Rook u, of maak u gebruik van 'n E-sigaret? (hoeveel per dag?)** | | | |
| Do you get heartburn / reflux<br>Kry u sooibrand – refluks | | | When did you last eat or drink? Time<br>Wanneer laas het u geëet of gedrink:Tyd |
| **Is there anything else your anaesthetist should know?<br>Is daar enigiets anders wat u narkotiseur behoort te weet?** | | | |

## Annexure 2: Global fee member advisory

SASA PRIVATE PRACTICE BUSINESS UNIT
SOUTH AFRICAN SOCIETY OF ANAESTHESIOLOGISTS

# GLOBAL FEE
## 3rd Advisory

29 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.**

## PRACTICAL ADVICE WHILE NOT ABLE TO PARTICIPATE IN GLOBAL FEE PRODUCT

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 guidance on such patient interaction further 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 upfront) 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 after service delivery.
- Advise the patient to seek reimbursement from their funder.

## Annexure 3: Global fee patient notice

SASA
PRIVATE PRACTICE
BUSINESS UNIT
SOUTH AFRICAN SOCIETY OF ANAESTHESIOLOGISTS

# GLOBAL FEE
## Patient Notice

Dear Patient

12 April 2017

**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 e.g.: ICPS), Ophthalmology (eye care – e.g.: 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 e-mail: 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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