CODING GUIDELINES 2015
1. INTRODUCTION

This guideline is intended to be used as an aid to correct coding practice. As such the guideline is intended to be utilised to guide SASA members in the appropriate, reasonable and the ethical use of codes when providing an invoice for their services to patients. In the event that the Society receives a billing related complaint, the billing practice would utilise this guideline as the basic source document for evaluation thereof. Responsibility for ethical and correct coding remains with the individual practitioner delivering the service.

In the process of compiling the guidelines the Society takes various factors into account which include fairness towards patients as well as members, transparency, as well as the principles of ethical practice.

2. GENERAL PRINCIPLES

a. Services involving administration of anaesthesia are reported using the method as described in the South African Medical Association Medical Doctor Coding Manual (latest edition).

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

c. Standard anaesthesia services may include but are not limited to general, regional, supplementation of local anaesthesia, or other supportive services to afford the patient the anaesthesia care deemed optimal by the anaesthesiologist during any procedure. Monitored anaesthesia care is included in the service and the reporting of any professional anaesthesia services is reported as if a general anaesthetic was administered.

d. Standard anaesthesia services include the anaesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services (e.g. ECG, temperature, blood pressure, oximetry, and capnography). Unusual forms of monitoring (e.g. intra-arterial, central venous and Swan-Ganz) are not regarded as standard anaesthesia care.

e. 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.

f. Time units are added according to the actual time spent providing the anaesthesia service.

g. Modifying units are added according to several technical factors which may complicate the anaesthesia and/or require the application of increased levels of expertise or care

h. A consultation component for evaluation and/or management of the patient is added.

i. Any additional procedures done by the anaesthetist during the course of the peri-operative period are reflected in the procedure units and/or ultrasound units.

j. The use of special equipment, if owned by the practitioner, is not included and billed in addition.

k. 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.

l. 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.

3. REPORTING OF ANAESTHESIA SERVICES

a. All anaesthesia values are determined by adding a Base Unit Value (only one Base Unit Value can be used), which is related to the complexity of the service, plus Modifying Units (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).

b. 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. This includes the value of all usual anaesthesia services except for the time actually spent in anaesthesia care plus any modifiers.
c. Anaesthesia charges must be calculated by means of a conversion factor (RCF) since the charges are not based on fixed amounts. The conversion factor is the Rand value associated with each unit of a code.

d. There are four separate Rand Conversion Factors: one for anaesthetic units, one for consultation units, one for procedure units and one for ultrasound units, each with its own value.

e. The total fee for the procedure = (Consultation Units X RCF\textsuperscript{1}) + (Anaesthetic Units X RCF\textsuperscript{2}) + (Procedure Units X RCF\textsuperscript{3}) + (Ultrasound Units X RCF\textsuperscript{4}) where, the Anaesthetic Units = Base Units + Time Units + Modifying Units.

f. 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.

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

4. BASIC UNIT VALUE

a. 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).

b. The basic value units have two components:
   - The first component reflects all usual services included in the anaesthesia service. Usual services include: administration of fluids and/or blood products incident al to the procedure and interpretation of non-invasive monitoring (ECG, temperature, blood pressure, oximetry and capnography).
   - 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.
   - For example, the basic value for the anaesthesia service related to a closed reduction of a radius fracture might be 3,00 anaesthetic units, as it has an average requirement in terms of expertise, training or risk. The basic value for an anaesthesia service associated with an intrathoracic coronary artery bypass graft procedure will be 15,00 anaesthetic units, reflecting the high level of risk, training or expertise required.

c. Four exceptions to using the basic value are listed:
   - 0034 - A minimum basic value of 5 Anaesthetic units are allowed for all procedures of the head, neck or shoulder girdle, requiring field avoidance.
   - 0032 - Any procedure performed in any position other than lithotomy or supine has a minimum basic value of 5 anaesthetic units.
   - 1807 - A laparoscopic / endoscopic procedure will have a minimum basic value of 5 anaesthetic units.
   - 0040 - The basic anaesthetic units for procedures performed for phaeochromocytoma shall have a minimum value of 15,00 anaesthetic units.
   - 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.

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

e. The following are excluded from the Basic Unit Value:
   - All consultation and postoperative management codes e.g. the pre-anaesthetic risk assessment, in-hospital consultation codes and ICU codes.
   - 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 intubation, management of a patient-controlled analgesic (PCA) pump and one lung ventilation.
   - Unusual forms of monitoring e.g. use of trans-oesophageal echocardiography (TOE), utilising ultrasound to aid nerve block and line placement and use of a bronchoscope to confirm ET tube placement or perform fibre-optic intubation.
   - Use of special equipment that is owned by the anaesthesiologist e.g. an ultrasound machine, target-controlled infusion pumps, PCA devices and disposable PCAs.
5. CONSULTATION SERVICES

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

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

c. Unscheduled or emergency consultation services, AT home or rooms (0146) and AWAY from home or rooms (0147). Only one of these items may be used as an add-on to the consultation service (0151 or 0152 or 0153 and 0173 or 0174 or 0175), 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. (ie: treatment that cannot wait until the next scheduled/elective list or within a restricted time period of 24 hours from the time of diagnosis).

d. 0190 or 0191 or 0192 or 0193 - Consultation services provided at own consultation rooms (including pain and pre-operative clinic consultations) done prior to the anaesthetic to assess fitness for anaesthesia and to improve physical status prior to an anaesthetic, codes, will apply.

e. When writing special motivations for procedures and treatment without the physical presence of a patient (includes report on the clinical condition of a patient) 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) or 0190 should be used.

6. ANAESTHETIC TIME - 0023

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

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

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

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

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

7. EMERGENCY OR UNSCHEDULED ANAESTHESIA SERVICES - 0011

a. 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.

b. The conditions as outlined in the use of codes 0146 or 0147 applies.

8. OBSTETRIC ANAESTHESIA: GUIDELINE TO CODING

a. Labour epidural (2614)
• Pre-anaesthetic consultation (0151) plus 0146 or 0147 (as appropriate) unless elective induction of labour.
• Time charged using modifier 0023 of actual time spent attending to the patient, usually between 31-60 minutes (6-8 time units).
• It is appropriate to code for unscheduled time (0011) if the epidural is unscheduled.
• If an indwelling epidural catheter is inserted during placement, it is appropriate to use code 2804.
• 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.

b. Epidural labour patients progressing to caesarean or spinal for caesarean (2615): Same practitioner who placed the epidural involved.
   • No additional pre-anaesthetic consultation fee (0151) but 0146 or 0147 as appropriate.
   • Additional top-up times may be charged for the time spent with the patient prior to admission to the theatre.
   • Thereafter standard general anaesthetic reimbursement as if a separate procedure.

b. Epidural labour patients progressing to caesarean or spinal for caesarean (2615): Different practitioner from the one who placed the epidural.
   • Another consultation service is charged (0151) plus 0146 or 0147 as appropriate.
   • Thereafter standard general anaesthetic reimbursement as if a separate procedure.

c. The use of code 0039 (Control of blood pressure) during spinal or general anaesthesia for caesarean section.
   • The routine use of 0039 because of the expected blood pressure drop from a spinal anaesthetic and subsequent treatment thereof is not appropriate.
   • If the patient has a pre-existing pathological condition such as a cardiomyopathy, a critical valve lesion, hypovolaemic shock etc. which necessitates active haemodynamic support, it would be applicable to use 0039.

9. MANAGEMENT SERVICES

   a. 0109 – 15 consultation units: Post-operative assessment and management (hospital follow up consultation). Anaesthesiology does not have a global fee component and therefore if cardio-respiratory, pain or any other assessment or intervention is necessary, this code will apply.

   b. 1204 - 30 Clinical units. ICU category 1: Where the anaesthesiologist is responsible for intensively monitoring a patient peri-operatively, without active intervention. The code may be used once per calendar day.

   c. 1205 - 100 Clinical units. ICU category 2: Code to be used in the first 24 hours of active system support where the anaesthesiologist is the primary physician responsible for an patient.

   d. 1206 – 50 Clinical units. ICU category 2: Code for subsequent calendar days of active system support where the anaesthesiologist is the primary physician responsible for a patient up to a period of 14 days.

   e. 1207 – 30 Clinical; units. ICU category 2: Daily code to be used after 2 weeks of active system support where the anaesthesiologist is the primary physician responsible for a patient.

   f. 1208 - 137 Clinical units. ICU category 2 patient which requires multidisciplinary intervention or an ICU category 3 patient. The primary physician responsible for the patient use 1208 once for the first 24 hours (only one physician may use 1208 per patient).

   g. 1209 – 58 Clinical units. The anaesthesiologist takes part in the management of an ICU category 2 or 3 patient but is not the primary physician. Use once for the first 24 hours.

   h. 1210 – 50 Clinical units. The anaesthesiologist takes part in the management of an ICU category 2 or 3 patient but is not the primary physician. Use for subsequent calendar days.

   i. Ventilation codes (codes 1212-1214) may only be used if the anaesthesiologist is the primary physician responsible for the ventilation of the patient. Appropriate to be used by the anaesthesiologist if he/she
performs an emergency endotracheal intubation that is not part of an anaesthetic as part of the same procedure on the patient.

j. 1321 – 30 Clinical units. Stand-by fee for coronary angioplasty. Anaesthesiologist need not be present during the procedure, but must be available for resuscitation or emergency CABG surgery.

k. 1211 – 50 Clinical units per 30 minutes for the first hour, 25 Clinical units per 30 minutes after one hour to a maximum of 150 Clinical units. Cardio-respiratory resuscitation performed (not during anaesthetic). To be used as stand-alone code without adding any procedures like CVC insertion, intubation, time etc. (See Rule R). Consultation codes may be added (0147/0146, 0173).

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

10. MODIFIERS RELATED TO ANAESTHETIC TECHNIQUE

a. 0039 – Control of blood pressure: Deliberate control of the blood pressure: All cases up to one hour: Add 3 Anaesthetic units, thereafter add 1 additional Anaesthetic unit per quarter hour or part thereof. 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.

b. 0026 - 3 Anaesthetic units. One lung ventilation: Utilisation of one lung ventilation.

c. 0037 - 3 Anaesthetic units. Body hypothermia: Utilisation of total body hypothermia. This includes:
   • cardio pulmonary bypass cases where a heat exchanger is used
   • deep hypothermic arrest

d. 0038 – Peri-operative blood salvage: Add 4 Anaesthetic units for intra-operative blood salvage and 4 Anaesthetic units for post-operative blood salvage. Peri-operative blood salvage is appropriate for the collection of autologous blood intra-operatively and for the administering of salvaged blood (either from cell-saver or re-infusion drains) in the post-operative period.

e. 0041 – 3 Anaesthetic units. Hyperbaric pressurisation: Utilisation of hyperbaric pressurisation.


11. MODIFIERS RELATED TO AGE

a. 0019 – 50% rule. Surgery on neonates (up to and including 28 days after birth) and/or low birth weight infants (less than 2500g) under general anaesthesia (excluding circumcision): A 50% increase in anaesthetic time units for anaesthesiologists as well as a 50% increase for all procedures (i.e. placements of CVP’s, regional blocks) performed by the anaesthesiologist as part of the anaesthetic services provided.

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

c. 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 particular 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 and weighing more than 2500g, only modifier 0043 is coded for.

12. MODIFIERS RELATED TO PHYSICAL STATUS

a. 0018 – 50% rule. Surgical modifier for persons with a BMI of 35 or greater (calculated according to kg/m2): A 50% increase in anaesthetic time units for anaesthesiologists as well as a 50% increase for all procedures (i.e. placements of CVP’s, regional blocks) performed by the anaesthesiologist as part of the anaesthetic services provided.

b. 5431 – 0 Anaesthetic units. ASA 1: Normal healthy patient.
c. 5432 - 0 Anaesthetic units. ASA 2: Mild systemic disease.
d. 5433 – 1 Anaesthetic unit. ASA 3: Severe systemic disease, which limits normal activity.
e. 5434 - 2 anaesthetic units. ASA 4 - Severe systemic disease that is a constant threat to life.
f. 5435 - 3 Anaesthetic units. ASA 5 - A moribund patient who is not expected to survive without the operation.
g. 5436 – 0 Anaesthetic units. ASA 6 - A declared brain-dead patient whose organs are being removed for donor purposes.

13. MODIFIERS RELATED TO MUSCULOSKELETAL PROCEDURES

a. 5441 – 1 Anaesthetic unit. Musculoskeletal procedures specified with a "M" (Modifier), except where the procedure refers to the bones named in Modifiers 5442 to 5448.
b. 5442 – 2 Anaesthetic units. Musculoskeletal procedures involving the shoulder / scapula / clavicle / humerus / elbow joint / upper 1/3 tibia / knee joint / patella / mandible and/or tempero-mandibular joint.
c. 5443 - 3 Anaesthetic units. Musculoskeletal procedures involving the maxillary and/or orbital bones.
d. 5444 – 4 Anaesthetic units. Musculoskeletal procedures involving the shaft of femur.
e. 5445 - 5 Anaesthetic units. Musculoskeletal procedures involving the spine (excluding the coccyx) / pelvis / hip and/or neck of femur.
f. 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.
g. Musculoskeletal modifiers are only appropriate for procedures designated with the letter "M" added to the basic anaesthetic units. If anaesthesia is administered for procedures on more than one category of bone, the modifier for the highest category of bone concerned is applicable.

14. PROCEDURES PERFORMED BY THE ANAESTHESIOLOGIST

a. It is appropriate for anaesthesiologists performing procedures, to use the appropriate consultation and procedure codes when rendering a service not related to the administration of an anaesthetic. If a procedure is performed on a patient that is unscheduled and not related to the administration of an anaesthetic, it is justified to use code 0011 for the time spent performing the procedure, but not code 0023.
b. If the performance of a procedure is related to the administration of an anaesthetic, the appropriate procedure code is added to the anaesthetic account.
c. 1215 – 25 Clinical units. Insertion of arterial pressure cannula.
d. 1218 – 25 Clinical units. Insertion of central venous line. Any approach*
e. 1216 – 50 Clinical units. Insertion of Swan Ganz catheter.
f. 1202 – 40 Clinical units. Insertion of central venous catheter via peripheral vein in neonates.
g. 1408 – 91 Clinical units. Insertion of temporary dialysis line (e.g. Cooks catheter): any approach.
h. 0205 – 12 Clinical units: Intravenous treatment: Intravenous infusions (cut-down or push-in) (patients under three years): Cut-down and/or insertion of cannula - chargeable once per 24 hours. Chargeable by an anaesthesiologist provided it is not inserted in a theatre environment, i.e. ward, casualty or ICU/High care areas.
i. 0206 – 6 Clinical units. Intravenous treatment: Intravenous infusions (push-in) (patients over three years): Insertion of cannula - chargeable once per 24 hours. Chargeable by an anaesthesiologist if they are not the attending doctor either in the ICU/High care or involved in the pre- and intra-operative management of the patient, as this fee is included in the pre-operative consult and the fee for critical care services.
j. 1780 – 8 Clinical units: Gastric and/or duodenal intubation. Appropriate to be used by the anaesthesiologist if a gastric or duodenal tube was inserted, either under anaesthesia or awake. This code may also be used if an oesophageal dilator is passed by the anaesthesiologist.*
k. 0113 – 45 Clinical units. New born attendance: Emergency attendance to newborn at all hours (once per patient) (items 0107, 0109, 0111, 0145, 0146 and/or 0147 may not be added to item 0113). The specialist fee is appropriate for anaesthesiologists.

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

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

n. 5103 – 50 Ultrasound units. Ultrasound soft tissue, any region. Ultrasound used for the placement of venous and/or arterial access, and nerve blocks can be used by the anaesthesiologist if he/she performed the ultrasound. This code may only be used once per case/visit.

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

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

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

r. 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.

s. 1141 – 50 Clinical units. Placement of an intercostal drain.

t. 1127 – 90 Clinical units. Performing of percutaneous tracheotomy.

u. 1199 – 96,50 Clinical units. Pulmonary stress testing: For determination of VO2 max (only appropriate if own equipment is used).

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

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

x. 1234 – 40 Clinical units. Effort electrocardiogram with the aid of a special bicycle ergometer / treadmill. Appropriate code to be used for 6minute walk test (only appropriate if own equipment is used).

15. REGIONAL ANAESTHESIA AND PAIN MANAGEMENT

a. Routine post-operative pain management includes oral, intramuscular or intravenous medications.

b. Routine post-operative pain management provided by the anaesthesiologist and/or surgeon is included in the global fee for the surgical procedure.

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

d. 2799 - 36 Clinical units: An Intrathecal or spinal injection for pain management. This code should not be used if a single-shot spinal anaesthetic is the sole anaesthetic technique during the surgical procedure.

e. 2801 - 36 Clinical units: Placement of an epidural or caudal block.

f. 2802 – 25 Clinical units: Performance of a peripheral nerve block.

g. 2800 – 36 Clinical units: Performance of a plexus nerve block is reported for more complex nerve blocks.

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

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

l. 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.

m. Postoperative pain management services are not calculated based on time. These services are reported as a single, daily charge.

n. Procedures for chronic pain management (example epidural for pain) is only charged as a consultation service (0173-0175 or 0190-0192) plus the procedure code 2801 plus 2804 if appropriate – note there is no fee for anaesthetic time.

16. MONITORED (STAND-BY) ANAESTHESIA

a. Monitored anaesthesia care is defined as instances where an anaesthesiologist has been requested to provide specific services to a patient undergoing a planned procedure. The patient receives either local anaesthesia or no anaesthesia. However, the anaesthesiologist is required to provide pre-operative assessment, to remain in attendance during the procedure to monitor the patient and to administer additional anaesthesia should it be required and provide post-operative services as required.

b. The procedure should be assigned the applicable procedure code with time, modifying units, procedure units and consultation units being added as for general anaesthesia.

c. When an anaesthesiologist is requested by the attending medical practitioner to be present in the operating room to monitor vital signs and manage the patient on an anaesthesia level, even though the actual surgery is being done under local anaesthesia, calculations will be the same as if general anaesthesia had been administered (time + base unit value).

17. SEDATION

a. Sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or by light tactile stimulation. A distinction is also made between light sedation and deep sedation.

b. In light sedation, the patient responds to verbal or tactile stimuli, no airway intervention is required, spontaneous ventilation is adequate and the cardio-vascular function is usually maintained.

c. In deep sedation purposeful response is only after repeated or painful stimuli, airway intervention may be required, spontaneous ventilation may be inadequate and cardio-vascular function is maintained.

d. Deep sedation is therefore seen as an anaesthetic technique. According to a HPCSA Ruling (April 1987 Vol 6 p 295) a medical practitioner ‘was not permitted to perform procedures and simultaneously administer the anaesthetic’. If deep sedation was provided, a second practitioner had to be present to monitor the patient during the sedation period.

e. Sedation performed by the operator: No additional fee may be charged for the sedation if it is performed by the operator, except to remunerate him/her for the medicine used during the treatment if it is supplied by the operator. The conscious sedation in this scenario is included in the fee for the procedure performed.

f. Sedation performed by the operator with a second person (anaesthesiologist) participating in the general care of a patient during a surgical procedure: The anaesthesiologist is remunerated at the usual anaesthetic rates. Thus the operator under the “supervision of a second person” performs the sedation in this scenario. No fee is charged by the operator for performing the sedation. However, the anaesthesiologist on stand-by charges for a general anaesthetic as appropriate.

g. Sedation performed by an anaesthesiologist (not the operator): The account is rendered as for general anaesthesia. Conscious sedation is an anaesthetic technique that should be handled in the same way as for example an epidural anaesthetic.

h. 0020 – No unit value (descriptor only). This code may need to be used to indicate on the anaesthetic account that the procedure was performed in an unattached theatre suite as there may often not be an associated hospital theatre account. See example below.
18. USE OF OWN EQUIPMENT

a. 0007 – 15 Clinical units: Use of own equipment in theatre
   • When a practitioner utilises his/her own equipment (e.g. TCI infusion pump), code 0007 may be added to the account.
   • 0007 may only be used once per procedure irrespective of the number of items used (e.g. if two TCI pumps are used, 0007 are coded only once).
   • If the equipment in question are available for the anaesthesiologist's use within the facility that the service is being delivered, it is not considered appropriate to code for 0007, even if own equipment were used.
   • 0007 does not apply to PCA devices that are hired out for the use of patients. Code 1220 is appropriate in these cases.
   • This rule applies to all additional equipment except ultrasound equipment where code 0083 is applicable.

b. 0083 - Ultrasound equipment:
   • Where the ultrasound equipment being used to perform a soft tissue ultrasound or TOE examination is owned by a party other than the anaesthesiologist performing these procedures, the unit value of code 5103 and/or 3636 and/or 3637 is reduced by 33.33% - modifier 0083.
   • 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.
   • If the facility where the ultrasound procedures are being performed has ultrasound equipment readily available to the practitioner, the unit value of 5103 / 3636 / 3637 should be reduced by 33.33% irrespective of whose equipment were used.

19. ASSISTANT ANAESTHESIOLOGIST / ANAESTHETIST – 0029

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

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

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

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

e. The total unit value of modifier 0029 will not be less than 7 units (modifier 0035 – refer to section 3(g)).

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

20. CHRONIC PAIN MANAGEMENT SERVICES

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

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

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

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

e. 2791 - 65 Clinical units. Trigeminal ganglion: Injection of cortisone.
f. 2793 - 170 Clinical units. Trigeminal ganglion: Coagulation through high frequency.

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

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

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

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

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