User Guide – UPFS 2009
Version 1

Uniform Patient Fee Schedule For Paying Patients Attending Public Hospitals

Guide Reviewed and Edited by UPFS Tariff Committee
National Department of Health (NDoH)
Hallmark Bldg
Pretoria
June 2009 Edition
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ABOUT THE GUIDE

Welcome to the User Guide for the Uniform Patient Fee Schedule. We have tried to provide a reference document for the fee schedule that is easy to use and hope you will find it helpful. This document should be read in conjunction with the relevant fees manual for your Provincial Department of Health or Organisation (if not a Provincial Department of Health).

The first section of the User Guide provides an explanation of the principles of the UPFS to assist you in applying the UPFS. This guide also includes a number of appendices, the first of which contains the detailed tariff rates (Appendix A). Again, please refer to your provincial fees circular for the date upon which they come into effect.

The appendices include information that will vary depending on the circumstances of each Provincial Department of Health or Organisation using the UPFS. Appendix B includes the forms which have been developed by other provincial departments to record the services delivered to patients in order to bill debtors. These have been included for guidance purposes.

Appendices C-N include the reference books for clinical staff recording services as well as the Price lists. Sufficient copies of the codebooks should be made available to the clinical departments within the hospital. The UPFS is being used in all Provincial Departments of Health and provincial guidelines will influence some aspects of the UPFS. Therefore, ensure you have access to your provincial guidelines when applying the UPFS to patients at your hospitals.

The UPFS is subject to annual review as approved by the NHC. This User Guide reflects the latest changes made to the UPFS.

Information and documents relating to the UPFS can be found on the web site of the Department of Health at www.doh.gov.za/programmes/UPFS

UPFS National Project Team
June 2009.
1. ABOUT THE UNIFORM PATIENT FEE SCHEDULE

1.1 Introduction to the Uniform Patient Fee Schedule

The Uniform Patient Fee Schedule has been developed to provide a simpler charging mechanism for public sector hospitals. Many hospitals currently treat patients for health services rendered. These tariffs are applicable to all full paying and subsidised patients. The UPFS replaces the itemised billing approach with a grouped fee approach.

The Uniform Patient Fee Schedule was designed with the following objectives in mind:

- It must be simple to implement in both manual and computerised systems
- It should be based on health service activities (activity-based costing)
- Linked to National Health Reference Price List (NHRPL) for initial purposes
- It must be easy to adjust for changes in cost structure
- Different levels of health service delivery should be taken into consideration
- The schedule must be complete

1.2 Who The UPFS Applies to

Classification of Patient Categories

Patients are classified into the following groups for the purposes of service fee determination:

- Full paying patients (Externally Funded & Private Hospital Patients)
- Subsidised patients:
  - Fully Subsidised
  - Partially Subsidised

This classification of patient categories was accepted by the PHRC in April 2002. (Refer to Annexure H, which is included as an appendix to this document.)

1.2.1 (a) Full Paying Patients

This category of patients includes but is not limited to externally funded patients, patients being treated by their Private Practitioner and certain categories of Non-South African citizens. They are liable for the full UPFS fee as listed in Appendix A of this document.

(b) Subsidised Patients

- These are patients who do not fall in the category of full paying patients.
- Subsidised patients are further categorised based on their ability to pay for health services into three categories: H0, H1 and H2.
- The fees payable by subsidised patients are expressed as a percentage of the fees payable by full paying patients as determined by the latest edition of the Uniform Patient Fee Schedule (UPFS).
- The classification of dependants is determined by the classification of their guardians.
- Subsidised patients are divided into two main groups:
  - Fully Subsidised
  - Partially Subsidised

(c) Patients qualifying for full subsidisation: HO

Patients in this group receive all services free of charge. Patients must provide proof in terms of the conditions set out in Annexure H, in order to be classified into this group.
Patients can only qualify for full subsidisation if they are referred to a hospital from Primary Healthcare Services. This is not the default classification for a patient attending a public hospital. Unless proof of status is produced a patient is classified according to the means test. The default classification for a person without income is therefore H1.

(d) Patients qualifying for partial subsidisation (H1 and H2)

This is the default group for subsidised patients and the level of subsidisation depends on the assessment of income (frequently called the means test). Patient earning above this amount will pay full UPFS fees. Patients must provide proof in terms of the conditions set out in Annexure H

1.2.2 Free Services

There exist under certain circumstances in which patients are exempted from paying for health services, independently of their classification as full paying or subsidised patients. These circumstances have a statutory basis and apply only to the episode of care directly related to the circumstances under which the patient has qualified for free services. This classification is not a default / basic classification. Refer to Annexure H for a summary of free services.

NB: Extent of free services may vary among provinces in terms of the Provincial Ordinances.

1.2.3 Managing Change

The Uniform Patient Fee (UPFS) Versions:

Annual editions of the UPFS will be identified with the edition year, e.g. UPFS 2009 v.1. Release of new UPFS tariffs and user-guides will be distributed by NDoH to the CMS and BHF and not to individual entities such as, i.e. Schemes and Administrators.

2. Basic Principles of the Uniform Patient Fee Structure

2.1 Facility Fee

All tariffs with the exception of anaesthesia are divided into two components. The first component is termed “facility fee”. This component of a tariff reflects the overhead costs of providing the environment in which the Healthcare Service is delivered and is in line with the cost structures associated with Level 3, 2 and 1 facility.

2.2 Professional Fee

The second component is the “Professional Fee” which is structured to reflect the costs of healthcare professionals rendering services to the patient. When the Healthcare Professional, employed by the applicable Provincial Health Department, renders a service, or is ultimately responsible the applicable professional fee should be recorded.

2.2.1 For the purpose of the UPFS the categories of Healthcare Professionals are:

(a) General Practitioner:

The General Practitioner (GP) fee should be added to the facility fee whenever the General Practitioner, employed by the public health authority, is the ultimate responsible Healthcare professional, regardless who renders the service to the patient.

Note: General Practitioner refers to Medical Officers, Senior Medical Officers and Registrars.
(b) Specialist:
The Specialist fee should be added to the facility fee whenever a Specialist, employed by the public health authority is the ultimate responsible Healthcare Professional, regardless who renders the service to the patient.

**Note:** Specialist refers to Professors, Specialists, Senior Specialists and Consultants.

(c) Nurse Practitioner:
The Nurse Practitioner fee should be added to the facility fee whenever a Nurse Practitioner employed by the public health authority has overall responsibility for the treatment of the patient for the purposes of the episode. It should therefore only be charged where the Nurse is the ultimate responsible professional for rendering services to and including the treatment of the patient, e.g. at the Midwife Obstetric Unit (MOU). The same principle would apply in the case of referred treatment, e.g. where wound care or stoma therapy was practiced by a Nurse practitioner at an outpatient clinic or where diabetic treatment was supplied. In this case the treatment tariff will be charged applying the Nurse Practitioner professional fee.

**Note:** Nursing Practitioner refers to all registered nursing categories.

(d) Allied Health Therapist:
The Allied Health Therapist fee should be added to the facility fee whenever a Clinical Psychologist, Social Worker, Physiotherapist, Occupational Therapist, Speech and Hearing Therapist, Podiatrist, Radiographer, Dietician, Oral Hygienist or other supplementary health professional employed by the public health authority render the service. Paramedics also fall into the category of Allied Health Therapist.

(e) Private Practitioners:
In some instances a private professional may treat a patient in a public hospital, e.g. an Eye Specialist may use the facilities in the local public hospital to treat day patients. Distinguishing between facility and professional fee components of the tariffs, allow hospitals to charge only the facility component when Practitioners not employed by the hospital render the service in a public facility (including sessional Doctors treating private patients outside their session time). This principle would apply where a private midwife or Allied Health therapist utilises the public facilities.

**2.2.2 Sessional Doctors:**
Where private professionals are employed by the health authority to treat patients on a sessional basis, the hospital should levy the professional fee. The professional should not bill, since they are already receiving payment from the health authority. Where a private Practitioner who is not a sessional doctor, renders the service, no professional fee is levied by the public facility. The private Practitioner on a separate account then renders the professional fee component; **UPFS tariffs are not applicable to private practitioners.**

**2.2.3 The principle of telephonic or written medical instruction:**
Where a private Practitioner is responsible for the treatment of a patient and specific procedures are performed on instruction, either telephonically or in writing, by the Nurse Practitioner employed by the public hospital, the nurse professional fee should be charged for the procedures. This would be in addition to the appropriate consultation tariff, where no professional fee for the private professional will be levied by the public facility in this regard (with the exception where an agreement has been reached between the private Doctor and the hospital).
THIS PRINCIPLE OF TELEPHONIC OR WRITTEN MEDICAL INSTRUCTION WOULD APPLY TO THE FOLLOWING PROCEDURES:

- Electrocardiogram (ECG) (1232)
- Nebulisation in rooms (1136)
- Insertion of I.V. line children under two years (0205)
- Insertion of I.V. line adult (0206)
- Foetal heart tracing test (2610)
- Insertion of urine catheter male (1996)
- Insertion of urine catheter female (1997)
- Stitching of wound (0300)

2.2.4 Within a training capacity,
Where a student performs services with or without supervision, the general rule regarding the ultimate responsible professional fee will apply.

![Diagram of Basic Tariff Structure]

**Figure 1: Basic Tariff Structure**

2.3 Flat Fees

Most tariffs are based on a flat fee for services, rather than the itemised approach adopted in the past. The fees have been calculated to include overheads cost such as electricity and provision of general equipment as well as the cost of consumables. The methodology has also taken into account the salaries of support staff. The intention is to reduce the amount of items that appear on bills but to still reflect the value of the service being provided. However, it has not been possible to completely remove itemized billing since some costs fluctuate too much. Therefore itemized billing still applies to certain key services.
2.4 **Categories of Service**

For many of the tariffs, the possible services have been grouped into categories. Whenever this is the case, the fee to be charged is determined by the category into which a particular service falls. Examples of these tariffs are Ambulatory, Minor, Radiology and Theatre procedures. More information on how to apply such tariffs is given in the specific tariff section later in this guide.

2.5 **Relationship to the National Health Reference Price List (NHRPL)**

The NHRPL was used as the reference for developing the Uniform Patient Fee Schedule. The billing rules of this reference price list should be inferred where the UPFS does not make a rule explicitly.

2.6 **UPFS Coding Structure**

The UPFS consist of a Tariff Group, which identifies the type of service provided; Global Code and or a Sub-Code which identifies either the:

- Prefix “56” (optional), which is a unique identifier for Public Hospitals:
- Facility Fee: Prefix 03, 02, 01 (optional)
- Professional Fee
- Procedure Category
- Sub-code, which may be an in-house code e.g. pharmaceutical Items.
- Miscellaneous codes

2.7 **Nappi Codes**

The public Hospitals are not compelled to use NAPPI or any other code, which is regarded as the prescribed pharmaceutical coding structure currently utilised by private entities.

2.8 **Procedure Codes**

The public Hospitals are not compelled to use CPT–4 or any other procedural coding structure, which is regarded as the prescribed coding structure currently utilised by private entities.

2.9 **Non-Chargeable Items (items included in the Facility fee)**

(Refer to the guideline, which is an appendix to this Guide)

2.10 **Laboratory Services**

2.10.1. **National Health Laboratory Services (NHLS)**

- NHLS is an entity separate from the department of health and is responsible for billing Full-paying patients as per their prescribed tariffs (NHRPL-HS).
- Where provincial hospitals are entitled to charge for services outside NHLS, the NHRPL-HS less Vat shall be charged.

2.10.2. **Other Laboratory Services**

- Where provinces utilises their provincial laboratory services, which is outside the NHLS agreement, such as in the case of i.e. Kwa-Zulu Natal (KZN).
- The province will levy laboratory investigations as per their respective Service Level Agreement (SLA),
- Will submit laboratory invoices to the debtor.
- These services may be levied at a “flat rate” or itemised.
2.11 National Support Unit

The UPFS Steering Committee of the National Department of Health provides support for the Uniform Patient Fee Schedule. The team is responsible for working with Provincial Departments of Health to implement the UPFS. In addition, the team negotiates with various funding bodies to ensure the maximum impact of the UPFS.

2.12 Updating The Uniform Patient Fee Schedule

The Uniform Patient Fee Schedule is updated on an annual basis to allow for inflation. In addition, groups of tariffs are identified each year for a more fundamental review of their structure. Thus the complete Uniform Patient Fee Schedule will be assessed in detail every three to five years. This review function is performed by the UPFS Steering Committee in response to the information provided about the tariffs by the Provincial Departments of Health and other organisations using the UPFS. The National department of Health envisaged that implementation of the revised UPFS shall be implemented 1st April each year, to ensure readiness of all provinces as well as to allow all stakeholders / funders with a more manageable process.

2.13 Pre-Authorisation, Authorisation And Re-Authorisation

All externally funded patients, i.e. confirmed medical scheme patients, including state Departments patients (Department of Justice, Correctional services, Department of Defence and SAPS), attending Public health institutions whereby the rule compels authorisation / pre-authorisation, shall ensure that the aforementioned is obtained. The onus is on the respective patient to obtain the authorisation (pre-authorisation) number, and is not the responsibility of the public health institutions to ensure the above. The relevant institution as per the scheme rules shall manage re-authorisation. Late validation of funded patients, due to non-declaration at time of treatment, shall be managed accordingly once membership is confirmed.

2.14 Prescribed Minimum Benefits (PMB/s) Chronic Disease List (CDL)

Medical Schemes Act no. 131 of 1998, Regulation 8;(2) Any benefit option that is offered by a medical scheme must reimburse in full, without co-payment or the use of deductibles, the diagnostic, treatment and care costs of the Prescribed Minimum Benefit conditions (specified in Appendix J) in at least one provider or provider network which must at all times include the public hospital system.

2.15 Answering Questions About The Fee Schedule

If you have a query about a particular aspect of the Fee Schedule that is not answered adequately in this guide, kindly liaise with Supervisor or the Head of Revenue at your institution. They in turn should contact the Finance Directorate at the Provincial Office for clarification. If, together you are unable to find the answer, the Provincial UPFS representative should be contacted at the UPFS National Project Department whereby a query tracking/FAQ is to be instituted whereby they will be responsible for determining the answers to questions and building up a database of questions raised by all the Provincial Departments of Health.

2.16 Acknowledgement

The update of the user guide is a result of the culmination of workshops held during 2005, which involved invaluable input and critical review from the provinces and NDoH. A special acknowledgement to the following persons: UPFS steering Committee, U.Le Roux (NDoH), K. Toerien and S. Munro, M. Davies (WCDoH), Andre Geldenhuys (FSDoH), Prof. Sathekge (GDoH-Nuclear Medicine; Pretoria Academic), Dr Nel (FSDoH; Nuclear Medicine).
3. **Explanation of Tariffs**

The tariff groups are:

- 01 Anaesthetic
- 02 Confinement
- 03 Dialysis
- 04 Medical Report
- 05 Imaging
- 06 Inpatients
- 07 Mortuary
- 08 Pharmaceutical
- 09 Oral Health
- 10 Consultation
- 11 Minor Theatre Procedures
- 12 Major Theatre
- 13 Treatments
- 14 Emergency Medical Services
- 15 Assistive and Prosthetic Devices
- 16 Cosmetic Surgery
- 17 Laboratory Services
- 18 Radiation Oncology
- 19 Nuclear Medicine
- 20 Ambulatory procedure
- 21 Blood and Blood Products
- 22 Hyperbaric Treatments
- 23 Consumables (Not included in the Facility Fee)
- 24 Autopsies

NB: Refer to Appendix 6.1 for the complete list of tariff values

### 3.1 Ambulatory Procedures

**When the tariff applies:**

This tariff applies to a simple procedure that can be of an investigative / diagnostic / treatment nature, and shall include the interpretation thereof. The services may be performed in a procedure room, ambulance, at the patient's bedside or at an accident site, regardless of the facility available. Selected procedures may be Nurse or Allied Health worker driven. May require local anaesthetic (infiltration or topical) but shall exclude general anaesthetic and conscious sedation.

**Examples (Refer to APPENDIX D)**

Intravenous therapy infusion (IVI), ECG, Nebulisation, Application of plaster of paris (POP), Insertion Urine Catheter, Minor sutures, Audio tests etc.

**How to use the tariff**

The tariff to be charged depends into which category a procedure falls. The tariff structure consists of a facility fee and a professional fee. (Specialist, General Practitioner, Nurse and an Allied Health Worker).

(The codebook giving the procedures and the category of tariff to charge is included as an appendix to this Guide.)
Rule:

1. If an ambulatory procedure e.g. Insertion of Urinary catheter is performed in addition to a minor / major theatre procedure, the insertion of the Urinary catheter shall additionally be charged as an ambulatory procedure.
2. The fee shall include consumables BUT shall exclude consumables as otherwise specified; “Consumables not included in the facility fee”.
3. Ambulatory procedures are grouped into two categories depending on the complexity and cost of the procedure.
4. Specific procedures are charged per intervention or otherwise specified as per 24 hour.
5. In the case of more than one professional the rule of the ultimate professional responsible for rendering the service, that professional fee will still apply.
6. No anaesthetic tariff or additional charge is levied for supplies or drugs used in the administration of anaesthesia.

Action required:
For each procedure; -
Record the name /s of the procedure performed
Look-up the category of the procedure and record it
Record the name of the health professional performing the procedure
Indicate whether the professional is private professional or not
If the healthcare professional is not a private practitioner, determine the category of the health care professional responsible for the service and record it.

3. 2 Anaesthesia

When the tariff applies

The tariff is charged for general or other anaesthetic (conscious sedation, spinal- or epidural injections and anaesthetic blocks), administered by a professional other than the person doing the procedure. The tariff is a professional fee only. The administration of a local anaesthetic is excluded in this tariff. This will form part of the facility fee of the applicable theatre tariff.

How to use the tariff

The tariff is based on the type of procedure for which the anaesthetic is administered. The tariff is divided into three groups based on the complexity and average duration of the anaesthetic procedure. The codebook giving the procedures and the category of tariff to charge is included as an appendix to this Guide.

Action required

For each procedure:-
Record the name/s of procedure performed
Look up the category of procedure and record it
Record the name of health care professional administering the anaesthesia
Indicate whether professional is a private professional or not.
If the health care professional is not a private professional, determine the category of the health care professional responsible for the service and record it.

Rule:

1. No additional charge is levied for supplies or drugs used in the course of the anaesthesia.
2. There is no facility component for this tariff since anaesthesia supplies are included in the procedure facility component.
3. Where more than one procedure is performed at the same time, both anaesthetic category and the procedure is billable.

3.3 Assistive Devices And Prosthetic Devices

(a) Assistive Devices

This charge applies when assistive devices are issued to patients. Assistive devices are any device and ergonomic solution capable of reducing the handicap experienced by an individual.

When the tariff applies

This charge applies when a device is issued and fitted or training is provided to the patient.

How to use the tariff

The itemized cost of the devices forms the facility fee of the device as well as assessment and prescription. The initial assessment of the patient’s need should be billed at the Outpatient Consultation rate. Subsequent and follow-up consultations and fitting of the device up to a maximum of 3 contact sessions should form part of the device fee. Provinces may determine the item and the price structure for itemised billing as per the National / Provincial Price List (Tender).

Action required

Make an itemized list of devices issued to the patient and keep records of all vital particulars.
Record the name and category of healthcare professional issuing the assistive device.

(b) Prosthetic Devices (1520)

Prosthesis is an artificial item that is implanted during a formal surgical procedure. The device is encapsulated within the body structure of a patient and includes components such as pins, screws, K-wires and plates, as well as joint replacements, cement (palacos) and pacemakers.

How to use the tariff

The itemised cost of the device forms the facility fee component of the prosthetic devices tariff.

Action required

Make an itemised list of devices issued to the patient
Record the name and category of healthcare professional issuing the prosthetic device.
An invoice may be submitted on request.

3.4 Autopsies

The undertaking of a post mortem on a patient that has died in or outside the hospital, is only paid for if the request is specifically received from family or another third party. This service will be rendered based on the prepayment fee.
3.5 Blood And Blood Products

This tariff applies to blood and blood product administered to patients. This tariff applies to blood screening, autogeneous transfusion etc. The tariff shall exclude e.g. specialised Administration sets provided by South African National Blood Services (SANBS) and Western Cape Blood Transfusion Services (WCBTS). The actual cost of the blood must be charged as per the SANBS and WCBTS pricelist, which is an appendix to the guide. (Appendix I). This charge will be itemised or “flat rate” as per the respective province.

3.6 Confinement

When the tariff applies

The tariff is inclusive of:

- all modes of delivery (including caesarean)
- all inductions of labour (medical or surgical);
- intrapartum Para cervical and pudental blocks;
- foetal blood sampling;
- sympyphysiotomy;
- repair of cervical tears;
- drainage of vulva haematoma;
- repair of second-degree tear;
- resuscitation of new-born by obstetrician;
- intrapartum amnioscopy;
- application of scalp leads;
- manual removal of placenta;
- correction of uterine inversion;
- repair of third degree tear;
- repair of episiotomy;

How to use the tariff

- NB: The confinement tariff differentiates between Natural Birth (2614) and Caesarean Section (2615).
- The confinement fee shall exclude the In patient stay of the mother but must be charged additionally;
- When the Healthcare Professional, employed by the applicable Provincial Health Department (Medical officer or the Professional nurse) renders a service or is the ultimate responsible, the applicable fee should be recorded.
- If the services rendered are the responsibility of a private Medical Practitioner, no professional fee should be charged.
- If the private Medical Practitioner or Private Midwife fails to be in time for the delivery and the public hospital staff performs the delivery, the health establishment may charge for this service; The responsible healthcare professional, which is available at the facility and performs the delivery, the applicable professional fee should be charged.
- No day tariffs are levied for the newborn baby, unless it is admitted into a unit not normally used for well babies (e.g. Neonatal unit or ICU).
- Where ill new–born babies are cared for in a nursery, in the absence of neonatal unit / ICU, a general ward fee tariff shall apply.
- False labour (missed confinements) should be billed as an inpatient – or outpatient visit (pending on whether the patient was admitted or evaluated as an outpatient) and services recorded accordingly.
- One confinement is charged, irrespective of a multiple delivery.
- Services rendered at a Midwife Obstetric Unit are charged at the professional level of the Nurse Practitioner (Applicable to Natural Birth)
The initial evaluation to determine if the mother should be admitted as an inpatient is billed as a consultation tariff.

The evaluation of the foetus is billed as an ambulatory tariff (2610 Tococardiography) where applicable.

Medical services, not related to the pregnancy, are excluded from these free services and shall be charged accordingly.

Any visits/admissions relating to complications must be billed in addition.

The confinement fee shall apply up until the six-week post-partum follow-up visit, where no complications exist.

Self-Funded patients being treated by their private practitioner shall be liable for the full UPFS facility fee.

Anaesthesia and imaging are levied additionally where applicable.

Rules for Caesarean Section

No theatre tariff is charged for a Caesarean Section (procedure code 2615).

General Anaesthesia, Cat B applicable and is levied additionally.

Where a spinal injection (procedure code 3287) or epidural (procedure code 3288) is administered, the minor theatre procedure is levied in addition.

Where the epidural fails and the procedure requires general anaesthesia, the general anaesthesia is only chargeable.

Action required:

For each confinement:-
Record the name of health care professional responsible for the confinement
Indicate whether professional is a private professional or not.
If the health care professional is not a private professional, determine the category of the health care professional responsible for the service and record it.

3.7 Consultation

When the tariff applies
The tariff for an outpatient consultation applies when the healthcare professional personally takes down a patient’s clinical history, performs an appropriate clinical examination and, if indicated, prescribes or administers treatment or assists the patient with advice. Example, MOPD, SOPD, Optometry, Gynaecology, Ante-Natal Clinic, ENT, Dermatology etc.

Information required
Record the type of consultation – emergency or outpatient
Record the name of responsible health care professional for the treatment
Indicate whether professional is a private professional or not.
If the health care professional is not a private professional, determine the category of the health care professional responsible for the service and record it.

Rule

1. The same tariff applies for each follow-up consultation.
2. The tariff includes all consumables used during the consultation. The fee excludes medications dispensed to the patient.
3. An emergency consultation fee has been included to cover consultations in emergency/casualty / trauma units / departments.
4. No after-hour tariff applies, as it is included in the emergency consultation fee
5. If a procedure is performed in a procedure room at the time of a consultation, the fee for the consultation plus the fee for the procedure is charged.

Visits by Allied Health Practitioner

The first visit must be billed as a consultation fee (tariff code 1014) and the follow-up as a Treatment tariff (Tariff codes 1314 or 1324)

Home visits

When full paying patients are visited at their homes, only the applicable professional fee in respect of a routine consultation fee, plus additional services and the prescribed kilometre tariff for official vehicles must be charged. No facility fee will be levied in this regard.

Supply of oxygen equipment

This tariff shall apply to oxygen therapy as a home-based service i.e. the supply oxygen apparatus e.g. Regulators etc. (miscellaneous codes)

Rule

1. The supply of oxygen therapy as a home based service to hospital patients, i.e. H1 and H2 patient are exempted from paying.
2. Oxygen apparatus, as a rule is not supplied to full paying patients.
3. The hiring of such equipment to full paying patients, in exceptional cases, shall be levied as non-pharmaceutical items, as per relevant provincial in-house rule.
4. This tariff is non-refundable.
5. All oxygen equipment and cylinders remain the property of the State or the supplier.
6. If any category of patient does not return the equipment to the hospital, an account is issued to the patient for the full replacement cost of the equipment.

Visits to Mobile and Part-time Clinics

Full Paying Patients who make use of visits to mobile clinics and part-time clinics must pay the full UPFS routine consultation fee in respect of a general Medical Practitioner applicable to level 1 institution, plus additional services.

Persons Awaiting Trial

The maximum relevant professional fee for a consultation must be charged for each person awaiting trial treated by full time Medical Officers attached to state hospitals/institutions who do routine visits to police stations. A SAP 70 form to be obtained for account purposes.

3.8 Cosmetic Surgery

When the tariff applies:

This tariff applies to procedures on an elective basis and for non-medical reasons (also called cosmetic surgery). In most cases, surgery for non-medical reasons will need to be indicated by the relevant surgeon on a case-by-case basis. The tariff includes theatre time, all consumables and medical gasses used during the procedure. If the surgery is of a medical nature, the theatre rate applies.

How to use the tariff:
The procedures applicable to this tariff are grouped into four categories depending on the complexity and cost of the procedure. The tariff to be charged depends into which category the procedure falls. The Code Book giving the procedures and the category of tariff to charge is included as an appendix to this Guide.

The level of the professional determines the professional fee component performing the procedure. When more than one professional at different levels is involved in the procedure, the fee for the highest level professional is charged. Any prostheses used are charged for additionally using the assistive devices tariffs. The anaesthesia tariff applies in addition to this tariff.

**Action required**

For each procedure:

Record the name/s of procedure performed
Look up the category of procedure and record it
Record the name of healthcare professional performing the procedure
Indicate whether professional is a private professional or not
If the healthcare professional is not a private professional, determine the category of the healthcare professional responsible for the service and record it.

**Rule:**

1. All patients which includes the externally funded and subsidised patients, are requested a payment of 100% prior admission/ treatment.
2. Where an external Funder accepts liability, Pre-authorisation and a written guarantee of payment by the relevant Medical Scheme is mandatory.

3.9 **Consumables (Not Included in the Facility Fee)**

No facility fee is to be charged for these items.

**This tariff applies:**

- To high cost theatre and ward consumables and buy-outs.
- The actual cost is charged.
- An invoice will be supplied on request. (Buy-out only)
- Provinces may determine the item and the price structure for itemised billing as per the National / Provincial Price List (Tender).

**Action required**

Make an itemised list of consumables issued to the patient

3.10 **Cremation Certificate**

**When the tariff applies:**

A charge (facility fee) per certificate for the completion of a cremation certificate, whether it be the medical attendant’s certificate, the confirmatory medical certificate or the authorisation for a cremation by a medical official. (B, C or E certificates) Funeral directors must apply in writing for the issuing of certificates and the tariff is payable strictly in advance before a certificate is made available.

**Action required**

Record the number of certificates issued.

3.11 **Dialysis**

Dialyses can be performed using three different methods.

**When the tariff applies**
3.11.1. Peritoneal Dialysis (Acute and Chronic).

This tariff consist of a rate per treatment day that covers the cost of insertion of catheter and shall include other consumables but exclude dialysate.

3.11.2. Haemodialysis (Acute and Chronic):

In the case of haemodialysis, the rate per treatment day (independent of duration of Treatment session), may be charge per 8 hours or part thereof. The tariff includes the preparation of the AV shunts, treatment and consumables but exclude dialysate. Where the formation of the AV shunt is surgically performed the appropriate major theatre fee shall apply (Prosthetic grafting 1385), where a permanent catheter is inserted in the radiology department the imaging procedure code 5072 shall apply;

3.11.3. Plasmapheresis

Plasmapheresis is a blood purification procedure used to treat several autoimmune diseases. It is used to remove antibodies from the bloodstream, thereby preventing the antibodies attacking their targets. It can also be defined as a therapeutic plasma exchange.

- It is used for the following disorders:
  - Guillain-Barre syndrome
  - Myasthenia Gravis
  - Chronic inflammatory demyelinating polyneuropathy
  - Thrombotic thrombocytopenic purpura
  - Paraproteinemic peripheral neuropathy
  - Hyperviscosity of blood

How to use the tariff:

Where patients are issued with e.g. dialysates etc for use at home, the patient should be billed on an itemised basis according to the pharmaceutical tariff. No pharmaceutical Facility fee will be charged.

Action required

For patients treated at the hospital:-

Record the number of days of treatment.
Record the name of responsible health care professional for the treatment.
Indicate whether professional is a private professional or not.
If the health care professional is not a private professional, determine the category of the health care professional responsible for the service and record it.

For patients treating themselves at home etc: -

Record the drugs issued to the patient as per line item.
Record the name of the professional issuing the drugs to the patient.

For patients requiring Continuous Veno-Veno Haemodialysis (CVVHD)
- Action is the same as for a patient treated at the hospital.

3.12 Emergency Medical Services (EMS)

When the tariff applies:
A number of fees apply to this section of the UPFS.

- Ambulance Transport (Ground and Air)
- Patient Treatment
- Rescue
- Medical Standby
How to use the tariff:

3.12.1 Ambulance Transport
Journeys are calculated on the basis of stages of 50 kilometres. The charge starts at
the point at which the patient is collected. Three levels of care have been identified;

1. Basic Life Support,
2. Intermediate Life Support
3. Advanced Life Support.

3.12.2 Patient Transport
This tariff applies to the transport of patients in a vehicle other than an ambulance,
where the patient does not require specific care during transportation, (e.g. Planned
patient Transport). The charge is based on stages of 100 kilometres from the point of
collecting the patient.

3.12.3 Emergency Road, Air and Rescue Services
Response Vehicle:
General rule shall apply where an emergency transport vehicle is dispatched. There is no
fee charged where a primary response vehicle is dispatched. The treatment and
transportation of patient / s must be billed at the level of care rendered as outlined in the
UPFS tariff. Example: Response vehicle dispatched with an ambulance to an emergency
site the paramedic (practitioner) assess, treats and accompanies the patient according to
advance life support interventions. The charge will be subject to appropriate service
rendered, i.e. advanced Life support

Road Treatment and transportation refers to the treatment and transportation of a
medical/trauma patient via ground ambulance;

Air Treatment and transportation refers to the treatment and transportation of a medical /
trauma patient via Air ambulance; (Rotary or fixed wing); (Refer to Annexure on Aero-
medical services guidelines).

Rescue Service refers: Specialised vehicle with appropriately trained rescue staff and
specialized equipment that is dispatched to assist with the treatment, disentanglement,
recovery and / or extrication of patients. Rescue Services are based on a per incident
charge, inclusive of all equipment utilized for the said purpose e.g. “Jaws-of-Life”.

For purposes of all patient treatment, transportation and rescue incidents, all attending
personnel MUST be registered with the Health Professions Council of South Africa.

3.12.4 Standby charge
This tariff consists of an hourly charge or part thereof, for medical standby at special
events such as sporting, political, religious, government, conferences or musical, as well
as an additional hourly charge for services provided by healthcare professionals.

Rules:

- A medical standby fee and health care professional fee must be charged for EMS
standby at events; Unless prior written approval to waiver such cost have been
obtained from the Political Head of Health;

- An Emergency assessment is chargeable equivalent to that of the AHW
professional fee of the Emergency consultation tariff (UPFS tariffs code 1024).
- Rescue is chargeable where provincial emergency medical services perform the primary rescue function;
- Standby charges must be settled in accordance to provincial directive or policy. Additional hours will be billed where and when applicable.
- With the standby services, additional kilometres are chargeable where applicable. (UPFS tariff code 1490)
- All EMS practitioners must ensure that the relevant Patient Report Form and charge sheets are completed in their entirety. Patient details, km travelled, procedures performed, medication administered, level of care and qualification of attending practitioner. Subject to Scope of Practice.

3.13 Examination (Medical Reports)

When the tariff applies:
This tariff is levied for the completion of a report for insurance or any other purpose and shall include original or copies thereof, e.g. RAF medico-legal reports. Where an additional clinical examination, imaging and other procedures are undertaken for the completion of the report, the relevant charges for those services will be applicable. This shall exclude cremation certificates.

How to use the tariff:

The tariff fee is payable strictly in advance before any information is disclosed. This tariff grouping accommodates:
- The supplying and/or the completion of medical reports/records (original or copies); and
- The completion of certificates/forms; (original or copies)
- As well as the supplying of reports/records, copies of X-Ray films.

Information may only be disclosed or medical reports issued if the patient gives his/her written permission. This service is excluded for the purposes of life insurance, however where copies of existing medical reports may be requested for life insurance purposes it shall be levied at the prescribed tariffs.

Work Evaluation: where a private company refers a patient to a hospital, rendering occupational therapy for services to assess patient’s fitness, the full UPFS tariffs per consultation shall apply and the additional cost for medical reports.

NOTE:
The completion of forms includes:
RAF reports:
1. FORM 1 (RAF1), which is the Personal claim, is to be completed by the patient (optional).
2. FORM 2 (RAF 2), which is the Supplier claim is mandatory and needs to be completed by the delegated service provider / official.

Medico-legal services for –
- Assault;
- Rape;
- Driving a vehicle under the influence of alcohol or drugs;
- Mentally ill persons for referral for observation under the Mental Health Care Act, 2002 (Act No 17 of 2002);
- Certifying / confirming death;
- Post mortem investigations;
- Court cases;
- Original sick leave certificates;
- Reports to private medical Practitioners in respect of private inpatients and outpatients treated by hospital medical staff;
- Reports to private medical Practitioners in respect of Occupational Injuries and Diseases Act cases treated by hospital medical staff;
- Reports to Social Service Organisations in respect of certified and subsidised patients; Medical reports to medical schemes in order to evaluate payment for further treatment.

**Rule**

1. Where copies of medical reports/records are required, the hospital shall levy, irrespective of the treating service provider.

**Information required**

Record the number of examinations
Record the name of responsible health care professional for the examination
Indicate whether professional is a private professional or not.
If the health care professional is not a private professional, determine the category of the health care professional responsible for the service and record it.

### 3.14 Hyperbaric Oxygen Therapy

Is defined for the treatment mode in which the patient is entirely enclosed in a pressure chamber of increased atmosphere pressure for medical therapy. This chamber compresses air and is used for numerous ailments such as inflammation, scurvy, arthritis and rickets etc. This service is provided at specific public health facilities and includes services rendered by South African Military Health Services. (SAMHS)

**How to use the tariff**

The tariff structure shall be levied as a facility fee and the professional fee as provided by the respective health institution. The tariff shall be levied as per arrangement with the respective institution.

**Rule:**

1. The charges shall be applicable as per the tariff schedule (Appendix A), where a province has an agreement, the respective institution rendering the service will determine the tariff.

### 3.15 Imaging

**When the tariff applies**

This tariff is charged for any radiological procedures and intervention, as well as imaging modalities prescribed and rendered to an inpatient or an outpatient includes all radiological, gamma camera, lithotripsy and ultrasound. The tariff is inclusive of all consumables, films, and medication but exclude contrast media used. This tariff also applies when an image is taken at bedside.

**How to use the tariff**

Imaging procedures are divided into four categories and the fee to be charged for a particular procedure depends on the category into which the procedure falls. The codebook giving the procedures and the category of tariff to charge are included as an appendix to this Guide.

**Rule**

1. If a radiologist or General practitioner reports on the image, the specific professional component should be charged.
2. If not, the healthcare therapist rate applies. Radiologists / Radiographers, employed by the hospital render the service in a public facility (including sessional radiologists /
radiographers treating private patients with in their sessional time), may not levy the professional fee, since they are already receiving payment from the health authority.

3. The hospital should levy the professional fee.

4. Private Radiologist utilising hospital equipment for private patients, may only levy the professional fee and not the facility fee, and the state hospital are therefore entitled to levy the facility fee.

5. Where private practitioners refer the patient for radiological procedures to the public facility, the public facility shall levy both the facility and professional fee.

6. Video Telemetry:

The following tariffs are in respect of Video Telemetry and are applicable to those Institutions where these services are rendered:

- Electroencephalogram monitoring
- Monitoring for localisation of cerebral seizure focus using computerised sixteen or more channel EEG, which may include video recording (e.g. for pre-operative localisation): Each full 24-hour period.
- Tariff shall be determined according to the respective institution providing the services.

7. Tomography:

8. Fluoroscopy:

3.16 Inpatient Tariffs

When the tariff applies
The inpatient tariffs apply when a patient is admitted to a bed on a ward. There are tariffs depending on the type of ward a patient is admitted to. The fee includes all medication dispensed from ward stock to the patient for the duration of their stay, as well as other consumables used. The charge excludes theatre procedures, radiology and laboratory investigations, physiotherapy treatment, medication not on the EDL list and discharge medication (TTO's) etc.

How to use the tariffs
- Different fees are applicable, depending on the type of ward into which the patient is admitted.
- The boarder day rate is applicable to persons accompanying patients and receiving board and lodging from the hospital.
- With the exception of intensive care and high care wards, (general ward and chronic ward as per specific province), the duration of stay in a particular bed category is calculated by applying the 12-hour rule or by subtracting the admission date from the discharge/transfer date of a particular bed category.
- When a patient is admitted and discharged on the same day from a particular bed type, the bed type in which the patient spent the majority of time during that day will be applicable.
- If a patient is admitted and discharged on the same day from the hospital, the day tariff applies.
- The professional fee depends on the level of the professional responsible for the ward to which the patient is admitted.
- A general inpatient tariff is charged for services rendered to a patient while admitted to a bed in a general ward.
- A Day Ward is a day care unit, or where such a unit does not exist, a general ward, whereeto a patient is admitted for a specific examination or procedure and is supposed to be discharged before or on 23:00 on the day of admission.
- A Chronic Ward is a ward in a psychiatric hospital or a ward designated to admit psychiatric patients as identified in terms of the Mental Health Care Act (MHCA). This ward is specific for long-term psychiatric patients, rehabilitation patients etc, and shall exclude acute psychiatric cases. In the case where an acute psychiatric patient
requires admission, the general ward fee shall apply. This rule is subject to prior arrangement with the relevant institutions.

- Sub-acute facilities: A specialised, recognised and accredited facility where the following high function rehabilitation impaired categories are treated.

- Rehabilitation units for Stroke, Brain dysfunction (traumatic and non-traumatic), spinal cord dysfunction (traumatic and non-traumatic), Orthopaedic lower joint replacements, Amputations (lower joint extremity), Cardiac, Pulmonary and Major Multiple trauma.

- Psychiatric Rehabilitation units for Depression, Bipolar mood disorder, Dementia, Psychological behaviour disorder, Schizophrenia, Mental retardation, Eating disorder, Nor organic sleep disorder and Sexual dysfunction.

- Sub-acute facilities for Stroke, Brain dysfunction (traumatic and non-traumatic), spinal cord dysfunction (traumatic and non-traumatic), Orthopaedic lower joint replacements, Amputations (lower joint extremity), Cardiac, Pulmonary and Major Multiple trauma.

A Boarder is a person who with the written authority of the Head of the Institution or an officer that he/she had authorised to act on his/her behalf, is admitted because in the opinion of a doctor the person's presence is essential to the patient's recovery in or at such hospital. Boarder rates are to be settled in advance, unless prior arrangements have been made. This cost is not routinely reimbursed by Medical Schemes to the hospital/provider of healthcare services.

A live-in baby is a newborn infant of a mother who is still a maternity patient.

Rule:
1. No tariffs are levied for a live-in baby, unless it is admitted to a unit not normally used for well babies.

Ward Types: Basis of Charge
Intensive Care 12 hours
High Care 12 hours
General Ward per day or per 12 hours (As per respective province)
Day Ward per day
Chronic Ward per day or per 12 hours (As per respective province)

Action required:
Record the name of the ward and its type
Record the date and time the patient is admitted to the ward
Record the date and time patient is discharged or transferred from the ward
Record the name of the health care professional responsible for the ward
Indicate whether professional is a private professional or not.
If the health care professional is not a private professional, determine the category of the health care professional responsible for the service and record it.

3.17 Laboratory Services

This tariff applies
To laboratory services rendered to patients (IP and OPD).
The Drawing of bloods will be charge as per contact.
Refer to National Health Laboratory Services (NHLS), 2.10.1. and 2.10.2.

3.18 Major Theatre Procedures

When the tariff applies
This tariff applies to all procedures performed in an operating theatre. The tariff includes theatre time, all consumables and medical gasses used during the procedure. An operating theatre is a room where surgical intervention or procedures take place in a sterile environment i.e. a room specially designed, built and designated as an operating theatre where strict aseptic conditions are required.

How to use the tariff

The procedures applicable to this tariff are grouped into four categories depending on the complexity and cost of the procedure. The tariff to be charged depends into which category the procedure falls. The codebook giving the procedures and the category of the tariff to charge is included as an appendix to this Guide.

The level of the ultimate professional performing the procedure determines the professional fee component. When more than one professional at different levels is involved in the procedure, the fee for the highest level professional is charged.

Multiple therapeutic procedures/operations under the same anaesthetic:

Unless otherwise identified in the tariff when multiple therapeutic procedures/operations add significant time and/or complexity, and when each procedure/operation is clearly identified and defined, the following shall prevail:
- Each procedure shall be charged according to facility and professional fee as per specific category.
- Anaesthetic fee shall be charged according to facility and professional fee as per specific category.

Endoscopic procedures

Where more than one diagnostic endoscopic procedure is performed under the same anaesthetic, each individual diagnostic endoscopic procedure should be specified and charged for a professional and facility fee applicable to the category of the individual procedure.

Lithotripsy Procedures

1. The Tariff for Lithotripsy shall be levied as per arrangement with the respective institution, NHRPL less VAT

Action required:

For each procedure:
- Record the name/s of procedure performed
- Look up the category of procedure and record it
- Record the name of health care professional performing the procedure
- Indicate whether professional is a private professional or not.
- If the healthcare professional is not a private professional, determine the category of the health care professional responsible for the service and record it.

Post-operative Care and Follow-up Consultations

Rule:

1. The fee in respect of an operation or procedure shall include normal after-care for a period not exceeding ONE month. Normal after-care refers to an uncomplicated post-operative period not requiring any further incisions, treatment or emergency care.

2. When post-operative care/treatment of a prolonged or specialised nature is required, the appropriate fee will be levied.
3. Free post-operative care will also apply in instances where the original procedure was performed at any public hospital. However, where the procedure was performed in the private sector, the consultation and the relevant professional fee must be charged.

4. The fee for certain procedures e.g. stitching of wounds and applying plaster-of-paris, includes the removal thereof and is inclusive in the;

- Initial / original visit and no additional fee should be charged for the follow-up visit.
- Where the original procedure was performed at a private facility, the consultation and relevant professional fee must be charged.

5. The treatment facility fee and the nurse professional fee should be charged where a patient is referred to the hospital for postoperative wound care.

3.19 Minor Theatre Procedures

When the tariff applies

The tariff applies to minor procedures, which require limited instrumentation and drapery, and is only doctor driven and shall apply to EMS medical services where applicable. May require the administration of: conscious sedation, nerve blocks, epidural, spinal anaesthetic and / or general anaesthetic. No sophisticated monitoring is required but resuscitation equipment (trolley) must be available. Examples: Insertion of an Inter-costal Drain, Central Venous Pressure Line (CVP), Lumbar Punctures (LP), Arterial Lines, specific Endoscopic Procedures, etc.

How to use the tariff

Minor theatre procedures are grouped into four categories depending on the complexity and cost of the procedure. The tariff to be charged depends into which category a procedure falls. The value of the professional fee to be charged is determined by the category of the professional performing the procedure.

Rule:

1. If a minor theatre procedure, e.g. Insertion of an inter-costal catheter is performed in addition to a major theatre procedure, the insertion of the inter-costal catheter must be charged as a minor theatre procedure.

2. The fee shall include specified consumables, which is generally included in the facility fee, BUT shall exclude consumables as otherwise specified by; “Consumables not included in the facility fee”.

3. In the case of more than one professional performing the procedure, the fee for the professional who is ultimate responsible for the services, the highest tariff for that professional will be charged.

4. The professional anaesthetic tariff shall apply where anaesthesia has been administered.

5. No additional charge is levied for supplies or drugs used in the course of the anaesthesia.

6. Although spinal (3287) – and epidural (3288) procedures are the administration of anaesthetic, these minor procedures must be charged in addition to the specific theatre procedure and relating anaesthetic tariff where it is administered or monitored by a professional other than the person doing the theatre procedure.
3.20 Mortuary

When the tariff applies
A per diem fee is chargeable for the storage of a corpse after the first 24 hours. This fee shall be the liability to the next of kin and the RAF (where applicable) where a valid claim has been instituted.

How to use the tariff
A daily facility fee is charged for the storage of a corpse after the first 24 hours. The storage of bodies of people that die outside the hospital is also charged at the UPFS rate.

Rule
1. Forensic mortuaries; maximum fee will apply.

Action required
Record the date and time the patient is admitted to the mortuary
Record the date and time patient is released from the mortuary

3.21 Nuclear Medicine and Radio-pharmaceutical (Isotope) Studies

This tariff is charged for nuclear procedures and radio isotopes and shall include all radiological, gamma camera, and ultrasound – intervention, as well as imaging modalities prescribed and rendered to an inpatient or an outpatient. The tariff is inclusive of all consumables, films, and medication but exclude contrast media and radiopharmaceuticals (isotopes.)

Rule
1. Charged according to imaging tariffs.
2. The isotopes will be itemized.
3. Prices as per cost price.

Action required:
For each imaging procedure: -
Record the name/s of imaging performed
Look up the category of image and record it
Record the name of health care professional performing the service
Indicate whether professional is a private professional or not.
If the health care professional is not a private professional, determine the category of the health care professional responsible for the service and record it.

3.22 Oral Health

When the tariff applies
This tariff is an all-inclusive fee for services rendered by an oral healthcare professional/dentist or oral hygienist.

How to use the tariffs
Oral procedures are grouped into four categories depending on the complexity and cost of the procedure. The tariff to be charged depends into which category a procedure falls. The codebook giving the procedures and the category of tariff to charge is included as an appendix to this Guide.

The value of the professional fee to be charged is determined by the category of the professional performing the procedure. In the case of more than one professional in different categories, the fee for the highest category of professional is charged.
Oral health care professional

If a dentist renders the service, the general practitioner fee applies. If a Periodontist, Maxillo-facial and Oral Surgeons, Prosthodontist, Oral Pathologist or Orthodontist renders a service, the specialist fees apply. Where either the oral hygienist or the dental nurse is rendering services as a separate episode, the professional fee for the allied health care professional applies.

Rule:
1. Any prostheses used are charged for additionally using the prostheses tariffs.
2. Where two or more relating oral health procedures are being performed in a theatre under General Anaesthetic at the same time, the applicable oral health procedure code is charged as one theatre tariff.

Action required:
For each procedure:-
Record the name/s of procedure performed
Look up the category of procedure and record it
Record the name of health care professional performing the procedure
Indicate whether professional is a private professional or not.
If the healthcare professional is not a private professional, determine the category of the health care professional responsible for the service and record it.

3.23 Pharmacy Tariffs

When the tariff applies
This charge applies when medicines are dispensed to patients on the basis of a prescription. This implies the itemisation of medication that is generally not included in a specific facility’s ward stock.
The charge for a particular medication comprises the itemised cost of medication plus the facility fee that is levied per prescription. All items on national tender are included in the list of charges (to be circulated). Items not on the national tender list must be added by the provincial Department of Health. The facility fee charge is fixed according to the level of the facility. Only one facility fee per 24-hour period may be levied for prescriptions issued to in-patients.

PS: Pharmacy

Pharmaceutical codes have been created to accommodate the differentiation between medicines dispensed for IP, OP, Chronic medicine, Immuno-suppressants, oncology and TTO, to ensure correct benefits allocated for the funded patients. Public Facilities / Institutions should take cognisance of medical schemes that may reject claims on the basis of “depleted Funds” for medicine prescribed, related to Prescribed Minimum Benefits (PMB’s) according to the Chronic Disease List (CDL). (Medical Schemes Act No. 19 of 2003)

How to use the tariff
The pharmacy tariff should be levied in conjunction with other services provided by the facility (e.g. as a result of a consultation or inpatient stay at the facility).

H1 and H2 Patients
The medication fee is included in the consultation outpatient visit fee, unless otherwise specified by the provincial governance.

Repeat Medicines
Patients are billed according to the respective provincial governance.

Incidental medication to patients from ward stock is not regarded as a course and is covered in the facility fee.
Rule (Itemisation)

1. Pharmaceutical items issued to the patient by a Pharmacist on the basis of a prescription and To Take Home Medication (TTO's), the actual cost is chargeable.

2. Pharmaceutical items which is generally not included in a specific facility's ward stock or medication needing Specialist motivation i.e. medication not generally on the EDL (Essential Drug List). The actual cost price is charged.

3.24 Radiation Oncology

This tariff apply to the relevant treatments and shall be charged in accordance with the National Health Reference Price List (NHRPL) excluding VAT.

3.25 Treatments

When the tariff applies
This tariff applies to all supplementary health treatment episodes including stoma therapy, irrespective of whether the treatment was given in a group or individual context.

This tariff applies where
A series of therapeutic treatments (in individual context), for instance a series of physiotherapy treatments, instruction and/or guidance to patients being treated example, disability, be it temporary or permanent, speech impediments and mentally retardation;

Group Therapy: When one professional health care worker instructs/gives guidance to two or more persons, which either follows or precedes the acute stage of individual treatment, as for example after coronary thrombosis, or psychiatric treatment, pre-natal and post-natal exercise sessions.

How to use the tariff
The charge is a rate per contact with the patient. For group treatment, the maximum number of individuals in the group should be twelve.
Different charges apply depending on whether the episode is in a group or individual context. The adaptation and fitting of assistive devices is also billed according to this tariff (the initial assessment is billed as a consultation). The tariff is applicable to both inpatients and outpatients.

Stoma Therapy
The treatment facility fee and the nurse professional fee should be charged where a patient is referred to the hospital on an out patient basis for post operative wound care. The same principle will apply in the case of referred treatment where stoma therapy was practised at an out patient clinic or diabetic treatment was supplied by a Nurse practitioner.

Rule:

1. The first visit by or to an Allied Health Practitioner or Nursing Practitioner must be billed as a consultation fee and the follow-up as a treatment fee. (UPFS consultation code 1024).

Information required:
Number of contacts with the patient.

Immunisation And Related Procedures For Foreign Travel Purposes

Action required
Make an itemised list of medication issued to the patient
Record the number of prescriptions

*When the tariff applies*

The full UPFS tariffs apply for all related consultations and relevant services and are applicable to all patient categories.