## DEPARTMENT OF LABOUR

## NOTICE 217 OF 2018

**PROPOSED ANNUAL IN MEDICAL SERVICE PROVIDERS, FOR 2018/2019 FINANCIAL YEAR**

**COMPENSATION FOR OCCUPATIONAL INJURIES ACT, 1993 (ACT NO. 130 OF 1993), AS AMENDED**

**ANNUAL INCREASE IN MEDICAL TARIFFS FOR MEDICAL SERVICE PROVIDERS.**

1. I, Mildred Nelisiwe Oliphant, Minister of Labour, hereby give notice that, after consultation with the Compensation Board and acting under powers vested in me by section 97 of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No.130 of 1993), I prescribe the scale of "Fees for Medical Aid" payable under section 76, inclusive of the General Rule applicable thereto, appearing in the Schedule, with effect from **1 April 2018**.

2. Medical Tariffs increase for **2018 is 6.4%** with exception of assistive medical devices.

3. The current **2017/ 2018** rate for assistive medical devices will prevail for 2018/2019 financial year.

4. The fees appearing in the Schedule are applicable in respect of services rendered on or after **1 April 2018** and **Exclude Vat.**

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**MN OLIPHANT, MP**

**MINISTER OF LABOUR**

**DATE:** 10/04/2018

## GENERAL INFORMATION / *ALGEMENE INLIGTING*

### THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

**The employee is permitted to freely choose his own service provider e.g. doctor, pharmacy, physiotherapist, hospital, etc**. and no interference with this privilege is permitted, as long as it is exercised reasonably and without prejudice to the employee or to the Compensation Fund. The only exception to this rule is in case where an employer, with the approval of the Compensation Fund, provides comprehensive medical aid facilities to his employees, i.e. including hospital, nursing and other services — section 78 of the Compensation for Occupational Injuries and Diseases Act refers.

In terms of section 42 of the Compensation for Occupational Injuries and Diseases Act the Compensation Fund may refer an injured employee to a specialist medical practitioner of his choice for a medical examination and report. Special fees are payable when this service is requested.

In the event of a change of medical practitioner attending to a case, the first doctor in attendance will, except where the case is transferred to a specialist, be regarded as the principal. **To avoid disputes regarding the payment for services rendered, medical practitioners should refrain from treating an employee already under treatment by another doctor without consulting / informing the first doctor.** As a general rule, changes of doctor are not favoured by the Compensation Fund, unless sufficient reasons exist.

According to the National Health Act no 61 of 2003, Section 5, a health care provider may not refuse a person emergency medical treatment. Such a medical service provider should not request the Compensation Fund to authorise such treatment before the claim has been submitted to and accepted by the Compensation Fund. **Pre-authorisation of treatment is not possible and no medical expense will be approved if liability for the claim has not been accepted by the Compensation Fund.**

An employee seeks medical advice at his own risk. If an employee represented to a medical service provider that he is entitled to treatment in terms of the Compensation for Occupational Injuries and Diseases Act, and yet failed to inform the Compensation Commissioner or his employer of any possible grounds for a claim, the Compensation Fund cannot accept responsibility for medical expenses incurred. The Compensation Commissioner could also have reasons not to accept a claim lodged against the Compensation Fund. In such circumstances the employee would be in the same position as any other member of the public regarding payment of his medical expenses.

**Please note that from 1 January 2004 a certified copy of an employee's identity document will be required in order for a claim to be registered with the Compensation Fund**. If a copy of the identity document is not submitted the claim will not be registered but will be returned to the employer for attachment of a certified copy of the employee's identity document. Furthermore, all supporting documentation submitted to the Compensation Fund must reflect the identity number of the employee. If the identity number is not included such documents can not be processed but will be returned to the sender to add the ID number.

The tariff amounts published in the tariff guides to medical services rendered in terms of the Compensation for Occupational Injuries and Diseases Act do not include VAT. All accounts for services rendered will be assessed without VAT. Only if it is indicated that the service provider is registered as a VAT vendor and a VAT registration number is provided, will VAT be calculated and added to the payment, without being rounded off.

The only exception is the "per diem" tariffs for Private Hospitals that already include VAT.

Please note that there are VAT exempted codes in the private ambulance tariff structure.

## *DIE WERKNEMER EN DIE MEDIESE DIENSVERSKAFFER*

***Die werknemer het 'n vrye keuse van diensverskaffer bv. dokter, apteek, fisioterapeut, hospitaal ens.*** *en geen inmenging met hierdie voorreg word toegelaat nie, solank dit redelik en sonder benadeling van die werknemer self of die Vergoedingsfonds uitgeoefen word. Die enigste uitsondering op hierdie reël is in geval waar die werkgewer met die goedkeuring van die Vergoedingskommissaris omvattende geneeskundige dienste aan sy werknemers voorsien, d.i. insluitende hospitaal-, verplegings- en ander dienste — artikel 78 van die Wet op Vergoeding vir Beroepsbeserings en Siektes verwys.*

*Kragtens die bepalings van artikel 42 van die Wet op Vergoeding vir Beroepsbeserings en Siektes mag die Vergoedingskommissaris 'n beseerde werknemer na 'n ander geneesheer deur homself aangewys verwys vir 'n mediese ondersoek en verslag. Spesiale fooie is betaalbaar vir hierdie diens wat feitlik uitsluitlik deur spesialiste gelewer word.*

*In die geval van 'n verandering in geneesheer wat 'n werknemer behandel, sal die eerste geneesheer wat behandeling toegedien het, behalwe waar die werknemer na 'n spesialis verwys is, as die lasgewer beskou word.* ***Ten einde geskille rakende die betaling vir dienste gelewer te voorkom, moet geneeshere hul daarvan weerhou om 'n werknemer wat reeds onder behandeling is te behandel sonder om die eerste geneesheer in te lig****. Oor die algemeen word verandering van geneesheer, tensy voldoende redes daarvoor bestaan, nie aangemoedig nie.*

*Volgens die Nasionale Gesondheidswet no 61 van 2003 Afdeling 5, mag 'n gesondheidswerker of diensverskaffer nie weier om noodbehandeling te verskaf nie. Die Vergoedingskommissaris kan egter nie sulke behandeling goedkeur alvorens aanspreeklikheid vir die eis kragtens die Wet op Vergoeding vir Beroepsbeserings en Siektes aanvaar is nie.* ***Vooraf goedkeuring vir behandeling is nie moontlik nie en geen mediese onkoste sal betaal word as die eis nie deur die Vergoedingsfonds aanvaar word nie.***

*Dit moet in gedagte gehou word dat 'n werknemer geneeskundige behandeling op sy eie risiko aanvra. As 'n werknemer dus aan 'n geneesheer voorgee dat hy geregtig is op behandeling in terme van die Wet op Vergoeding vir Beroepsbeserings en Siektes en tog versuim om die Vergoedingskommissaris of sy werkgewer in te lig oor enige moontlike gronde vir 'n eis, kan die Vergoedingsfonds geen aanspreeklikheid aanvaar vir geneeskundige onkoste wat aangegaan is nie. Die*

*Vergoedingskommissaris kan ook rede hê om 'n eis teen die Vergoedingsfonds nie te aanvaar nie. Onder sulke omstandighede sou die werknemer in dieselfde posisie verkeer as enige lid van die publiek wat betaling van sy geneeskundige onkoste betref.*

*Neem asseblief kennis dat 'n* ***gesertifiseerde afskrif van die werknemer se identiteitsdokument benodig word vanaf 1 Januarie 2004*** *om 'n eis by die Vergoedingsfonds aan te meld. Indien 'n afskrif van die identiteitsdokument nie aangeheg is nie, sal die eis nie geregistreer word nie en die dokumente sal teruggestuur word aan die werkgewer vir die aanheg van die ID dokument. Alle ander dokumentasie wat aan die kantoor gestuur word moet ook die identiteitsnommer aandui. Indien nie aangedui nie, sal die dokumentasie nie verwerk word nie, maar teruggestuur word vir die aanbring van die identiteitsnommer.*

*Die bedrae gepubliseer in die handleiding tot tariewe vir dienste gelewer in terme van die Wet op Vergoeding vir Beroepsbeserings en Siektes, sluit BTW uit. Die rekenings vir dienste gelewer word aangeslaan en bereken sonder BTW.*

*Indien BTW van toepassing is en 'n BTW registrasienommer voorsien is, word BTW bereken en by die betalingsbedrag gevoeg sonder om afgerond te word.*

*Die enigste uitsondering is die "per diem" tarief vir Privaat Hospitale, wat BTW insluit.*

*Neem asseblief kennis dat daar tariewe in die kodestruktuur vir privaat ambulanse is waarop BTW nie betaalbaar is nie.*

## CLAIMS WITH THE COMPENSATION FUND ARE PROCESSED AS FOLLOWS •
## *EISE TEEN DIE VERGOEDINGSFONDS WORD AS VOLG GEHANTEER*

1. New claims are registered by the Employers and the Compensation Fund and the **employer views the claim number allocated online**. The allocation of a claim number by the Compensation Fund, does not constitute acceptance of liability for a claim, but means that the injury on duty has been reported to and registered by the Compensation Commissioner. Enquiries regarding claim numbers should be directed to the employer and not to the Compensation Fund. The employer will be in the position to provide the claim number for the employee as well as indicate whether the claim has been accepted by the Compensation Fund • *Nuwe eise word geregistreer deur die werkgewer en die Vergoedingsfonds en die* ***werkgewer. Die eisnommer is opdie web beskikbaar****. Navrae aangaande eisnommers moet aan die werkgewer gerig word en nie aan die Vergoedingskommissaris nie. Die werkgewer kan die eisnommer verskaf en ook aandui of die Vergoedingsfonds die eis aanvaar het of nie*

2. If a claim is **accepted** as a COIDA claim, **reasonable medical expenses** will be paid by the Compensation Commissioner • *As 'n eis deur die Vergoedingsfonds* ***aanvaar*** *is, sal* ***redelike mediese koste*** *betaal word deur die Vergoedingsfonds.*

3. If a claim is **rejected (repudiated)**, accounts for services rendered will not be paid by the Compensation Commissioner. The employer and the employee will be informed of this decision and the injured employee will be liable for payment. • *As 'n eis deur die Vergoedingsfonds afgekeur* ***(gerepudieer)*** *word, word rekenings vir dienste gelewer nie deur die Vergoedingsfonds betaal nie. Die betrokke partye insluitend die diensverskaffers word in kennis gestel van die besluit. Die beseerde werknemer is dan aanspreeklik vir betaling van die rekenings.*

4. If **no decision** can be made regarding acceptance of a claim due to inadequate information, the outstanding information will be requested and upon receipt, the claim will again be adjudicated on. Depending on the outcome, the accounts from the service provider will be dealt with as set out in 2 and 3. Please note that there are claims on which a decision might never be taken due to lack of forthcoming information • *Indien* ***geen besluit*** *oor die aanvaarding van 'n eis weens 'n gebrek aan inligting geneem kan word nie, sal die uitstaande inligting aangevra word. Met ontvangs van sulke inligting sal die eis heroorweeg word. Afhangende van die uitslag, sal die rekening gehanteer word soos uiteengeset in punte 1 en 2. Ongelukkig bestaan daar eise waaroor 'n besluit nooit geneem kan word nie aangesien die uitstaande inligting nooit verskaf word nie.*

## BILLING PROCEDURE • *EISE PROSEDURE*

1. All service providers should be registered on the Compensation Fund electronic claims system (Umehluko) in order to capture medical reports. • *Alle mediese intansies moet geregistreer wees op die Vergoedings Kommissaris se nuwe elektroniese stelsel (Umehluko), om mediese verslae te dokumenteer.*

   1.1 Medical reports should always have a clear and detailed clinical description of injury
   1.2 In a case where a procedure is done, an Operation report is required
   1.3 Only one medical report is required when multiple procedures are done on the same service date
   1.4 A medical report is required for every invoice submitted covering every date of service.
   1.5 Service providers are required to keep original documents (i.e medical reports, invoices) and these should be made available to the Compensation Commissioner on request.
   1.6 If there's any referrals to another medical service provider, it should be indicated on the medical report.

2. Medical invoices should be switched to the Compensation Fund using the attached format. - Annexure D. • *Mediese rekeninge moet oorgeskuif word na die Vergoedings Kommissaris, deur die aangehegte formule te gebruik. Annexure D.*

   2.1. Subsequent invoice must be electronically switched. It is important that all requirements for the submission of invoice, including supporting information, are submitted • *Daarop volgende rekeninge moet elektronies ingedien word. Dit is belangrik dat al die voorskrifte vir die indiening van rekeninge nagekom word, insluitend die voorsiening van stawende dokumentasie.*

3. The status of invoices /claims can be viewed on the Compensation Fund electronic claims system. If invoices are still outstanding after 60 days following submission, the service provider should complete an enquiry form, W.Cl 20, and submit it ONCE to the Provincial office/Labour Centre. All relevant details regarding Labour Centres are available on the website www.labour.gov.za • *Die status van rekeninge kan besigtig word op die Vergoedings Kommissaris se elektroniese stelsel. Indien rekenings nog uitstaande is na 60 dae vanaf indiening en ontvangs erkenning deur die Vergoedings Kommissaris, moet die diensverskaffer 'n navraag vorm, W.Cl 20 voltooi en EENMALIG indien by die Arbeidsentrum. Alle inligting oor Arbeidsentrums is beskikbaar op die webblad www.labour.gov.za*

4. **If an invoice has been partially paid with no reason indicated on the remittance advice, an enquiry should be made with the nearest labour centre. The service**

**provider should complete an enquiry form, W.Cl 20, and submit it ONCE to the Provincial office/Labour Centre. All relevant details regarding Labour Centres are available on the website** www.labour.gov.za • ***Indien 'n rekening gedeeltelik betaal is met geen rede voorsien op die betaaladvies nie, kan 'n navraag by die Arbeidsentrum gedoen word. Die diensverskaffer moet 'n navraag vorm, W.Cl 20 voltooi en EENMALIG indien by die Arbeidsentrum. Alle inligting oor Arbeidsentrums is beskikbaar op die webblad*** www.labour.gov.za

5. Details of the employee's medical aid and the practice number of the referring practitioner must not be included in the invoice. • *Inligting van die werknemer se mediese fonds en praktyk nommer van die verwysende dokter moet nie ingesluit wees op die rekeninge nie.*

6. Service providers **should not generate the following** • *Diensverskaffers* ***moet nie die volgende lewer nie****:*

   a. **Multiple invoices** for services rendered on the **same date** i.e. one invoice for medication and a second invoices for other services • ***Meer as een rekening*** *vir dienste gelewer op* ***dieselfde datum****, bv. medikasie op een rekening en 'n ander dienste op 'n tweede rekening.*

*** Examples of the new forms (W.Cl 4 / W.Cl 5 / W.Cl 5F) are available on the website www.labour.gov.za •**
*** *Voorbeelde van die nuwe vorms* (W.Cl 4 / W.Cl 5 / W.Cl 5F) *is beskikbaar op die webblad www.labour.gov.za***

## MINIMUM REQUIREMENTS FOR ACCOUNTS RENDERED • MINIMUM VEREISTES VIR REKENINGE GELEWER

**Minimum information** to be indicated on accounts submitted to the Compensation Fund • ***Minimum besonderhede*** *wat aangedui moet word op rekeninge gelewer aan die Vergoedingsfonds*

- Name of employee and ID number • *Naam van werknemer en ID nommer*
- Name of employer and registration number if available • *Naam van werkgewer en registrasienommer indien beskikbaar*
- Compensation Fund claim number • *Vergoedingsfonds eisnommer*
- DATE OF ACCIDENT (not only the service date) • *DATUM VAN BESERING ( nie slegs die diensdatum nie)*
- Service provider's reference and **invoice number** • *Diensverskaffer se verwysing of* ***faktuur nommer***
- The practice number (changes of address should be reported to BHF) • *Die praktyknommer (adresveranderings moet by BHF aangemeld word)*
- VAT registration number (VAT will not be paid if a VAT registration number is not supplied on the account) • *BTW registrasienommer (BTW sal nie betaal word as die BTW registrasienommer nie voorsien word nie)*
- Date of service (the actual service date must be indicated: the invoice date is not acceptable) • *Diensdatum (die werklike diensdatum moet aangedui word: die datum van lewering van die rekening is nie aanvaarbaar nie)*
- Item codes according to the officially published tariff guides • *Item kodes soos aangedui in die amptelik gepubliseerde handleidings tot tariewe*
- Amount claimed per item code and total of account • *Bedrag geëis per itemkode en totaal van rekening.*
- It is important that all requirements for the submission of accounts are met, including supporting information, e.g • *Dit is belangrik dat alle voorskrifte vir die indien van rekeninge insluitend dokumentasie nagekom word bv.*
    - All pharmacy or medication accounts must be accompanied by the original scripts • *Alle apteekrekenings vir medikasie moet vergesel word van die oorspronklike voorskrifte*
    - The referral notes from the treating practitioner must accompany all other medical service providers' accounts. • *Die verwysingsbriewe van die behandelende geneesheer moet rekeninge van ander mediese diensverskaffers vergesel*

**Rules for payment of renal care accounts in terms of COIDA**

1. In terms of Sec 73 (1) of COIDA, the Compensation Fund shall pay reasonable medical costs incurred by or on behalf of an employee in respect of medical aid necessitated by such accident or disease.
2. The renal condition must be directly related to the nature of injury sustained or complications thereof.
3. Dialysis is always performed in accordance to a dialysis prescription
4. Dialysis prescriptions can be provided by a nephrologist or a medical practitioner with appropriate training in nephrology
5. Haemodialysis provided in a dialysis unit, applies to both outpatients and stabilized in-hospital patients
6. The global fee for haemodialysis (item 1851) requires regular routine visits to the patient during dialysis and covers:
    (a) Dialysis prescription
    (b) Assessment of dialysis adequacy
    (c) Revision of chronic medication
    (d) Counseling
    (e) Consultations for chronic and acute conditions
    (f) Acute medication and prescriptions
7. After a series of treatments prescribed by the nephrologist or a medical practitioner the renal dialysis practitioner should refer the employee back to the treating medical practitioner.
8. If further treatment is still indicated the treating medical practitioner should submit a medical report with clinical indications for further treatment.
9. A monthly medical report should be submitted and should the condition become chronic a medical report explaining such condition must be submitted to the Fund.
10. Codes:
    (a) 75148
    - Chronic haemodialysis for inpatients and outpatients in dialysis unit.
    - Charged once daily

    (b) 75176
    - Continuous ambulatory peritoneal dialysis for inpatients and outpatients in dialysis unit.
    - Charged daily.

    (C) 75177
    - Automated peritoneal dialysis
    - Charged daily.

    (d) 75150
    - Acute haemodialysis inpatient
    - Charged daily.
    - Applies to all acute dialysis including haemodiafiltration, intermittent and continuous modalities.

(e) 75151
(f) 75152
(g) 75156

Codes, **75151, 75152** and **75156** for CRRT in hospital patient, to be charged in ICU general ward or high care only.

## COMPENSATION FUND GUIDE TO FEES FOR RENAL CARE 2018

| CODE | SERVICE DESCRIPTION | 2018 TARIFFS |
|---|---|---|
| 75148 | Chronic Haemodialysis<br>( Bicarbonate Dialysate) | 2536.06 |
| 75176 | Global Fee for Continous Ambulatory Peritoneal (CAPD) per 30 day | 900.47 |
| 75177 | Global Fee for Automated Peritoneal Dialysis (APD), per 30 day period | 1250.08 |
| 75150 | Acute Haemodialysis | 5040.54 |
| 75151 | Treatment procedures for CRRT for up to 6 hours or part thereof | 364.82 |
| 75152 | Treatment procedures for CRRT for up to 12 hours or part thereof | 731.21 |
| 75154 | Treatment procedures for CRRT for up to 12 hours or part thereof | 1096.21 |
| 75156 | Treatment procedures for CRRT for up to 12 hours or part thereof | 1461.04 |

## Rules for payments of Social Worker services and Psychologists in terms of COIDA

## From 1 April 2018

1. In terms of SEC 73(1) of COIDA, the Compensation Fund shall pay reasonable medical costs incurred by on behalf of an employee in respect of medical aid necessitated by such accident or disease.
2. The need for the services must be directly related to the nature of injury sustained or complications thereof.
3. The services of a social worker shall be available only on a written referral by a medical practitioner. Medical invoice must be accompanied by a progress report and a referral letter. Without both these reports, payment will not be considered.
4. Code 89205 and 89206 can be claimed with code 89200, 89201 and 89202.
5. Only 10 sessions are payable (individual and group session together) per claim.
6. Unless timely steps are taken to cancel an appointment, the relevant fee may be charged to the employee.
7. If there is no active therapy for a period of three (3) calendar months, the treatment will be deemed to have terminated. Subsequently services will require a new referral letter and a treatment plan.

## PSYCHOLOGISTS

1. Only twelve(12) consultations payable, should further treatment be required, the treating medical practitioner must submit progress report to the Compensation Commissioner indicating a need for further treatment and only a maximum of 6 additional consultations can be approved. Without such a report payment cannot be considered.

## TARIFF OF FEES IN RESPECT OF SOCIAL WORKERS SERVICES
## EFFECTIVE 1 APRIL 2018

**The account for Social workers services must be accompanied by a referral from the treating doctor indicating the condition of the employee and indicating the need for such services**

| Item Code | Description | COIDA 2018 Tariffs |
|---|---|---|
| 89200 | Social worker consultation,counselling and/or therapy: 21-30min | 238.70 |
| 89201 | Social worker consultation,counselling and/or therapy: 61-60min | 525.17 |
| 89202 | Social worker consultation,counselling and/or therapy:81-90min | 811.78 |
| 89203 | Social worker consultation,counselling and/or therapy:111-120min(To be charged once only)can be claimed with item 89204 only. | 1098.10 |
| | **Group or Family consultation,counselling and/ or Therapy** | |
| 89204 | Social worker group consultation,counselling per patient:21-30min | 47.62 |
| 89205 | Social worker group consultation,counselling per patient:81-90min | 162.24 |
| 89206 | Social worker group,consutation,counselling and therapy,per patient:111-120min (To be charged once only) | 219.62 |

**TARIFF OF FEES IN RESPECT OF PSYCHOLOGISTS SERVICES**
**EFFECTIVE 1 APRIL 2018**

**The account for Psychologists must be accompanied by a referral from the treating doctor indicating the condition of the employee and indicating the need for such services**

| Item Code | Description | COIDA 2018 Tariffs |
|---|---|---|
| 862957 | Assessment, consultation, counselling and/or therapy (indivial). Duration 20 min | 266.23 |
| 862974 | Assessment, consultation, counselling and/or therapy (indivial). Duration 40 min | 621.30 |
| 862975 | Assessment, consultation, counselling and/or therapy (indivial). Duration 60 min | 976.38 |
| 862976 | Assessment, consultation, counselling and/or therapy (indivial). Duration 90 min | 1509.00 |
| 862977 | Assessment, consultation, counselling and/or therapy (indivial). Duration 120 min (can only be claimed once) | 2041.47 |

## Rules for payment of wound care accounts in terms of COIDA

1. In terms of Sec 73 (1) of COIDA, the Compensation Fund shall pay reasonable medical costs incurred by or on behalf of an employee in respect of medical aid necessitated by such accident or disease.
2. Referral letter with clinical indications for wound treatment should be submitted by the referring doctor and medical accounts from wound care practitioners should be accompanied by such motivation.
3. A regular medical report should b submitted to the Fund indicating progress of the wound.
4. The treatment of the wound should be directly related to the nature of injuries sustained by the employee.
5. Wound treatment within four months post operatively must be motivated according to rule 2 otherwise rules G (d) will apply. Rule G (d) of the General Practitioners and specialist Government Gazette stipulates that the fee in respect of a procedure shall include normal aftercare for a period not exceeding four months. If normal aftercare is delegated to any other health professional and not completed by the surgeon it shall be a surgeon's responsibility to arrange for the service to be rendered without extra charge.
6. The Surgeon should refer to the specific procedure code as outlined in the gazette for General Practitioners and specialist for a specific aftercare period.
7. After 10 conservative wound treatments the employee should be referred back to the treating doctor who should write a progress or final medical report. If further wound treatment is indicated the Compensation Fund should be furnished with motivation for further wound care treatment.
8. Wound treatment and cost of materials in the hospital is only payable to the hospital as a per diem tariff.

## COMPENSATION FUND GUIDE TO FEES FOR WOUND CARE 2018

| CODE | SERVICE DESCRIPTION | 2018 TARIFFS |
|---|---|---|
| **88002** | Per 60 minutes. First assessment of the patient and the wound. During this 1 hour assessment, full history of the patient is taken:<br><br>-Current use of medication,<br>-Patients with other underlying metabolic diseases<br>-HIV positive patients & those taking immunosuppressant drugs<br>-Severely injured patients, ICU, Oncology patients and those with PMB conditions<br><br>-Patients with infected wounds, swabs or tissue samples to be taken to the laboratory for culture and sensitivity.<br><br>-need for referral to other appropriate team members, physiotherapists, dieticians, psychologists, occupational therapists is established<br><br>-Education on healthy lifestyle and good nutrition<br>-Training & education in elevation of injured limbs is also covered.<br><br>-Patient education on wound healing and nutrition | **596.38** |
| **88001** | Per 30 minutes. This assessment code to be used only with first consultation in healthy patients with minimal factors which may influence healing.<br>All of the above applies, i.e. history, medication, education. | **298.19** |
| **88041** | Per 30 minutes. Wound treatment for complicated wound or potentially complicated wound in patient with underlying metabolic diseases. Patients requiring compression bandaging, sharp debridement, bio mechanical debridement, off loading, will also be billed on this code. Ongoing wound assessment and education with every visit. | **313.48** |
| **88411** | additional time - for additional 15 minutes | **84.11** |
| **88042** | Per 30 minutes. Wound treatment without complications, no sharp debridement, no bio mechanical debridement, no compression therapy or off loading will be billed on this code. Ongoing wound assessment and education with every visit. | **168.21** |

| | | |
|---|---|---|
| **880421** | Code for additional time for additional 15 minutes | **84.11** |
| **88040** | Per 30 minutes. This code should be used for assessing suture lines in uncomplicated patients. No additional time should be allocated to this code. | **129.98** |
| **88020** | Per specimen. This included correct collection of material, swab or tissue, completion of documentation and speedy delivery to laboratory. Ensuring copies of reports to relevant team members are received and acted upon. | **84.11** |
| **88049** | Emergency/ Urgent/ unplanned treatment | **168.21** |
| **88046** | Per Ankle Brachial Pressure Index (ABPI). Involves testing systolic blood pressure on both arms and both legs with a hand held Doppler. Interpretation of results will determine if patient requires referral to vascular surgeon and if compression bandaging is suitabl | **204.80** |
| **88047** | Trans cutaneous Oxygen pressure (TcPO2). Measured by a trans cutaneous oxymeter. This measures the oxygen pressure in and around injured tissue, also used in lower limb assessment where arterial incompetence is suspected. Accurate indicator arterial disease and expected would healing. | **428.17** |
| **88301** | Cost of material and special medicine used in treatment. Charges fo medicine used in treatment not to exceed the retail Ethical Price Lis | |

- Skin closure strips
- Fast setting bandages
- Dressings
- Micropore
- Wound plast
- Orthopaedic wool bandage
- Surgical tape
- Stockinette
- Ribbon Gauze
- Cotton wool
- Crepe bandage
- Elastic adhesive bandage
- Zinc oxide adhesive plaster
- Absorbent gauze and gauze swabs
- Elastoplast
- Cleaning / infusion solution
- Dressing tray
- Ointment
- Gloves
- Face mask
- Protective sheet
- Protective apron