OTASA

PROCEDURAL & CODING GUIDELINES

FOR

OCCUPATIONAL THERAPISTS

IN PRIVATE PRACTICE

ACCORDING TO THE NATIONAL HEALTH REFERENCE PRICE LIST 2006

Compiled in collaboration with INSTOPP

Revised: Coding & Procedural Committee April 2018

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I. INTRODUCTION

IMPORTANT NOTICE IN RELATION TO THIS GUIDE

"This is a guide to assist Occupational Therapists (OT's) in evaluating and subsequently coding their professional activities, within their scope of practice. This is to ensure that correct codes are attached to specific professional activities and procedures that OT's are trained and skilled to undertake. Each OT should evaluate the professional services s/he renders, and allocate the correct codes, and to those codes, fees they would deem to be a fair, reasonable and justifiable. Such fees must, by law, be communicated to clients prior to care being rendered.

This Guideline should not be construed as OTASA recommending any specific tariff or fee, and neither should it be construed as binding in terms of fee- or tariff-setting.

OTASA can merely recommend that certain procedures, or treatment, due to its practical and technical nature, carry certain weights, as opposed to others, based on a professional analysis of what such professional activities entail, when compared to others. OTASA in doing so, attempts to ensure that there are consistent codes being used across the profession for similar or the same treatments or procedures. OTASA is empowered to interpret these Guidelines, and apply it to specific cases at hand, and accordingly advise members, funders and others as to the appropriate use of the codes.

Each user of this Guide indemnifies and holds OTASA harmless for any consequence whatsoever that may flow from the use, interpretation and/or application of these Codes, whether supported, enforced, pronounced upon and/or interpreted by OTASA and/or by any of its office bearers, and/or any of its staff.

OTASA can also not guarantee that this Guideline, and the codes and weights contained herein, will be accepted by all funders of healthcare in all circumstances.

Each healthcare professional takes personal- and professional liability for all their services, coding, billing and claiming in his/her practice, and to verify scheme reimbursement rules from time to time."

1. SCOPE & PROFESSION OF PRACTICE

”OT’s use scientifically chosen meaningful activities to assist diverse patients with a range of problems to maximize their functioning. This empowers them to be as independent as possible and to experience the dignity and quality of life at work, at home and at play.”

Our Scope of Profession and Practice is currently being revised and updated with our Occupational Therapy Board in HPCSA.

OT’s in private practice typically work in one of five different fields:

1.1 MEDICO-LEGAL

Medico-legal work does not involve treatment, but is mainly concerned with evaluations/assessments, as well as the production of a report on the person’s functional ability, when an occupational therapist is commissioned by a legal practitioner from e.g. the Road Accident Fund, the insurance industry or retirement funds. Tariffs are subject to an agreement between the occupational therapist and the legal practitioner.

1.2 VOCATIONAL REHABILITATION

Therapists who work in vocational rehabilitation see mainly adult patients in the working age group, who are struggling or deemed unable to continue in / return to their previous employment, due to injury or disease. Individual or group based therapy may include work assessment, comprehensive rehabilitation, work hardening strategies and often recommendations to the employers regarding reasonable accommodation for workers, including to their work environment, who are deemed fit to return to work.

Rehabilitation goals of treatment may be paid for by medical schemes, the compensation commissioner, the employer or an insurance company. The occupational therapist could also consult with the employer on a generic basis, or provide a wider service, such as an ergonomic assessment of an entire working area. This would be subject to an agreement between the occupational therapist and the employer.

1.2 PAEDIATRICS

Children from birth to 15 years old. These patients may suffer from a variety of conditions, ranging from premature babies, cerebral palsy, blindness, deafness, developmental problems, coordination disorders, hyperactivity etc. Sensory Integration is a specific therapy modality & framework which requires further training. Children may be seen individually or in groups and treatment times typically range from 15 minutes to 60 minutes.

Treatment ranges from play therapy, fine motor activities, gross motor activities and others. These children need lots of space and extensive equipment for their treatment.

Therapy is usually paid for by a medical aid scheme or parents/guardians (as privately paying patients) based on their benefit plan and thus may require the parent/guardians themselves to settle an account should funding not be available. This needs to be clearly indicated on the consent form.

1.3 PHYSICAL CONDITIONS

These patients range in age from birth to geriatrics and may suffer from conditions such as rheumatoid arthritis, osteoarthritis, burns, upper limb injuries, strokes, head injuries, spinal cord lesions, cancer, back problems etc. These patients may receive treatment from up to twice daily to weekly or less frequently as required, and they may be seen individually or in groups. A large part of the work of an occupational therapist in this field is the skill of constructing custom made splints and pressure garments. Therefore, the material costs may be high in this area of practice. Other treatment includes the use of activities to improve a patient's independence in activities of daily living; home visits; work related spheres; cognitive and perceptual including visual retraining; craft activities, fine motor activities and also gross motor activities.

Treatment may be paid for privately by patients or by medical aid schemes based on their benefit plan and thus may require the patients themselves to settle an account should funding not be available. This needs to be clearly indicated on the consent form. The Compensation Commissioner, FEM or Insurer may also be a funder depending on the claim.

1.5 PSYCHIATRIC CONDITIONS

Patients treated by OT's may suffer from a variety of psychiatric conditions such as depression, stress, anxiety, obsessive compulsive behaviour, etc. These clients may be seen individually or in group therapy. Due to the nature of occupational therapy, therapy for patients with psychiatric conditions frequently requires the use of crafts, and therefore include the use of additional tools and materials. Patients may also be involved in skills re-training, social skills training, stress reduction groups, relaxation groups and groups teaching new coping strategies.

Treatment may be paid for privately by patients, by medical aid schemes based on their benefit plan and thus may require the patients themselves to settle an account. This needs to be clearly indicated on the consent form. The Compensation Commissioner, FEM, employer or Insurer may also be a funder depending on the nature of the intervention required.

2. FIRST LINE PRACTITIONER GUIDELINES

2.1 ABBREVIATIONS

Health Professions Council of South Africa	HPCSA
World Federation of Occupational Therapy	WFOT
First Line Practitioners	FLP
Health Care Professional	HCP
Occupational Therapy Association of South Africa	OTASA

2.2 INTRODUCTION

Occupational therapy is an autonomous health profession (WFOT autonomy statement). Occupational therapists registered with the HPCSA are considered first line practitioners. They are equal members of interdisciplinary health, social and rehabilitation teams and contribute their unique perspective on occupational performance to the decision-making on the design of the patient/client service programmes. (WFOT autonomy statement)

Those practitioners registered in the supervised practice category are excluded.

2.3 DEFINITIONS

There is significant confusion about the use of first contact, first line practitioner status and independent practice. For the purposes of this document, these terms are defined as follows:

2.3.1 First Contact status

This is the first practitioner with whom the patient comes into contact. It is possible that he/she may be able to assist, but would likely refer to other appropriate practitioners. An example would be a community based rehabilitation worker who comes across a person with a disability in the community.

2.3.2 First Line Practitioner Status[1]

This is a practitioner who can make an independent diagnosis and can treat such a condition, provided it falls within his / her scope of practice and level of training. Should the condition fall outside of their scope of practice or level of training, a referral to another appropriate practitioner will be made. The practitioner is autonomous and employs clinical reasoning in professional decision-making. It is acknowledged that first line practitioner status bears accountability as well as ethical and legal responsibilities. As per recent notifications from many medical schemes, a written referral from a medical practitioner/specialist doctor to an OT is required within hospital settings.

2.3.3 Independent Practitioner

An independent practitioner is someone who is registered as such by the HPCSA.

From these definitions, it follows that a first contact practitioner may be an independent practitioner or a first line practitioner, but this will not always be the case. It also follows that a fist line practitioner may be an independent practitioner, but there are other registration categories where practitioners may also be regarded as first line practitioners, e.g. persons registered in the category of Public Service. Where a person's registration status is changed from Independent Practice to Public Service for the purpose to ensure oversight by another occupational therapist, such a practitioner may still be regarded as a first line practitioner.

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[1] **Clarifying Statement – First line practitioner status**

The Occupational Therapy Association of South Africa (OTASA) noted that some fellow health professions have adopted the *first line practitioner* status. Occupational therapists are reminded that all health professions who register with the Health Professions Council of South Africa (HPCSA) as independent practitioners are bound by the same set of Ethical and Professional Rules (Health Professions Council of South Africa, 2008). The HPCSA confers professional status to all registered health practitioners, which is inclusive of the right to practice the profession for which he/she is qualified (www.hpcsa.co.za/professionals). As such, all health professionals, registered for independent practice, are permitted to perform the full range of acts as outlined in their respective Scopes of profession/practice.

Reference

- Health Professions Council of South Africa (2008). Guidelines of good practice in the health care professions. Ethical and professional rules of the Health Professions Council of South Africa as promulgated in Government Gazette R717/2006. Booklet 2. Pretoria: Health professions Council of South Africa.
- Health Professions Council of South Africa Website. For Professionals. Accessed on 22 April 2017.

2.4 ETHICO-LEGAL STATUS

The World Federation of Occupational Therapy has confirmed the autonomy of the profession of occupational therapy. The autonomy and FLP status of occupational therapy have been reflected in the updated Scope of the profession of occupational therapy. In addition, the Professional Board for Occupational Therapy, Medical Orthotics and Prosthetics has resolved in 2014 that the profession of occupational therapy is autonomous and as such practitioners can be regarded first line practitioners. In 2015, the Board was informed that Independent Practitioner status automatically confers first line practitioner status and as such the HPCSA regards practitioners registered in the independent practice category as FLPs.

2.5 PROFESSIONAL COMPETENCIES OF FIRST LINE PRACTITIONERS

In order to practice autonomously as a first line practitioner, the occupational therapist must have the following competencies:

2.5.1 Autonomous Decision - Making

FLP status means that a practitioner can make decisions regarding the intervention with their patient/client based on clinical reasoning, independently. Thus, a practitioner has the professional discretion to make a diagnosis and present solutions, based on sound verdicts, to proceed with management. Occupational therapists thus act independently on their own judgment, without supervision, as First Line Practitioners.

2.5.2 Advanced Expertise

- Appropriate experience in the chosen field of practice.
- Professional practice should be based upon a substantial body of advanced theoretical knowledge and skill.
- There is professional and legal obligation to update this knowledge and to keep abreast of new developments. This knowledge base should be substantiated by research.

2.5.3 Professional Organization

Membership of professional associations, e.g. OTASA is recommended for the following reasons:

- To allow for collective bargaining and negotiation with stakeholders e.g. funders.
- Keeping abreast of new developments.
- Contributing to the evidence-based practice protocols and to benefit from the knowledge of the collective.
- To provide a platform for addressing trends in complaints to the HPCSA about unprofessional conduct.

2.6 PROFESSIONAL CONDUCT AND ETHICS

Professional and ethical standards of conduct have been described in the regulations of the HPCSA as well as the Guidelines and booklets. Adherence is not negotiable.

2.7 IMPLICATIONS OF FIRST LINE PRACTITIONER STATUS

2.7.1 Diagnosis

Occupational therapists, similar to other health care practitioners, can provide a provisional clinical diagnosis (within their scope of practice and their level of training and experience), before further specialist investigations may be requested to substantiate the diagnosis.

Occupational therapists can provide functional, occupation-based diagnoses without referral for further specialist investigation.

2.7.2 Provision of Services

The World Federation of Occupational Therapy endorses “strategies that enable effective partnerships to be developed at individual, family and community levels” (WFOT consumer interface) between occupational therapists and occupational therapy service users. In order to achieve this, service users require direct access to occupational therapy and patient/client self-referral that will allow service users to meet their occupational therapy goals.

Service delivery models that allow patients/clients improved access to occupational therapy services through the ability to refer themselves directly to an occupational therapist are advocated. The terms direct access and patient self-referral refer to the circumstances where occupational therapy services are available to patients/clients without the requirement of a referral. A growing body of research evidence supports the clinical and cost effectiveness of such services and their acceptability among service users.

Notwithstanding funders' rules and terms of service, a referral from another health care practitioner is required to access occupational therapy services as per recent notifications. However a referral may not be required in out-patient services.

First line practitioners should apply the occupational therapy process in terms of assessment, intervention planning, execution and adaptation, as well as discharge planning, taking into account functional goals and prognosis. Occupational therapists are independent in their decision making, however, collaboration between occupational therapists and service users, as contained in the Consumer Protection Act should be considered in decision-making.

2.7.3 Cessation of Intervention

First line practitioners should evaluate outcomes and discharge patients/clients with or without input from another health professional (e.g. medical practitioner) or other third party. Discharge planning may include referral to an appropriate practitioner or resource. Cessation of intervention should take into account medical factors and functional prognosis.

2.8 CERTIFICATES

Occupational therapists are practitioners who are certified to diagnose and treat patients and are registered with a professional council established by an Act of Parliament (the HPCSA established by the Health Professions Act), as contemplated in section 29 of the Basic Conditions of Employment Act 7 of 1997. Occupational therapists as first line practitioners can issue certificates of attendance as well as certificates of incapacity to work or attend a training institution, in line with their scope of practice and level of training.

The requirements as set out in Rule 16 of the HPCSA's regulations pertaining to Professional Conduct should be followed.

2.9 REFERENCES

Health Professions Act of 1974, amended in 2007: Available at: http://www.hpcsa.co.za/downloads/health_act/health_act_56_1974.pdf Accessed 10/06/2016

WFOT 2007. Occupational therapy – professional autonomy. [Electronic] Available at: http://www.wfot.org/ResourceCentre/tabid/132/cid/31/Default.aspx Accessed 10/06/2016

WFOT 2010. Position statement: Consumer interface with occupational therapy (occupational therapists responding to the expressed needs of consumers). [Electronic] Available at: http://www.wfot.org/ResourceCentre/tabid/132/cid/31/Default.aspx Accessed on 10/06/2016

Reference NHRPL Occupational and Art Therapists, 1 January 2006 & NHRPL Occupational and Art Therapists, 1 January 2009 at www.medicalschemes.com

3. OCCUPATIONAL THERAPY CODING

3.1 UNITS ALLOCATED TO PROCEDURES

In order to evaluate the extent of work undertaken by OT's for occupational therapy services, units have been allocated to each procedure so that a monetary value can be calculated by each OT, depending on their practice value costing, reimbursements etc. for any procedure used.

Units are allocated to procedures based on the following basic principle:

15 UNITS ARE DEFINED AS AN EFFECTIVE TREATMENT OF A SINGLE DYSFUNCTION PERFORMED BY A BASICALLY QUALIFIED OCCUPATIONAL THERAPIST FAMILIAR WITH THE BASIC TREATMENT PROCEDURE. SUCH A TREATMENT PROCEDURE SHOULD BE EFFECTED IN A TIME PERIOD OF 15 MINUTES.

Additional principles that apply when units are allocated to procedures:

- Time in which a specific procedure should be effected.
- More units will be allocated to procedures where integrated treatment programmes are executed, indicating the principle of a composite fee as set by each OT according to his/her practice, patients, etc.
- Units allocated to procedures include time for preparation.
- Treatment time increases when more than one patient is treated at the same time, while units are reduced for each patient.
- Responsibility values which include knowledge, judgement, skill and risk.

II. GENERAL RULES

1. PROCEDURES IN OCCUPATIONAL THERAPY

Occupational therapy procedures are divided into four (4) sections namely:

1.1 Procedures of interviewing, guidance and consultancy

1.2 Procedures of evaluation

1.3 Procedures of therapy

1.4 Procedures to promote treatment

1.1 PROCEDURES FOR INTERVIEWING, GUIDANCE OR CONSULTANCY

CODE	DESCRIPTION	TIME	UNITS
108	Interview, guidance or consultation	30 min	21.25
109	Interview, guidance or consultation	15 min	10.63
107	Appointment not kept	N/A	N/A
110	Report requested by M/A	N/A	16.5
111	Report	N/A	-

GENERAL DEFINITION:

1. These codes are utilized for the **initial contact** as well as possible subsequent consultations with the patient and/or family / caregiver to commence / continue the interpersonal relationship between the therapist and the patient.
2. They are utilized for **obtaining** (via telephonic conversations / reading reports / case conferences or discussions / formal and informal interviews) **and interpreting relevant data** from key role players such as: medical practitioner / physiotherapist / nurse / social worker / psychologist / family member / employer / work supervisor / work colleagues/ teacher/etc.
3. **Reporting / liaison / discussion** with family or team members (not during a treatment session) to discuss: future health and progress / findings and recommendations / understanding of the condition and treatment to facilitate cooperation / progress made in treatment / guidance in dealing with specific problems.
4. **Guidance or training** of a parent / family member / caregiver / support staff / teacher or employer who is actively involved in the care / supervision of the patient under treatment.

RULES:

1. These codes are **time based** and may last from 15 – 90 minutes respectively
2. 108 and 109 may be billed separately related to the time allocated.
3. Code 109 may be billed in conjunction to code 108, up to four times, to a total time of 90 minutes.
4. Frequency: 108 once per week and 109 up to four times per week.
5. These codes indicate additional time spent with the client, as per their description, and may be billed in combination with an assessment (200) and treatment (300) code, as well as codes to promote treatment (400) within their guided frequency. This is dependent on the clinical intervention provided by the OT and supporting clinical documentation, i.e. 108 & 311 will indicate 30 minutes of consultation in addition to 30 minutes of individual & undivided attention with the client.

Code 107 holds NO unit / monetary value but should still be indicated on the client's account to indicate compliance or attendance. It is at the therapist's discretion to charge and is for the account of the patient. These conditions of charge for "appointment not kept" must be included in consent form. Medical Funds will NOT reimburse for this code.

NOTES:

1. These codes are not intended to be utilized with every treatment session – there must be a specific outcome of the interaction with the relevant role player, towards progression of the patient's treatment.
2. The frequency of guidance and or consultation would depend on the patient's presentation and the subsequent therapy.
3. Code 107 can be used by the occupational therapists when a client does not attend an appointment. However how this code is charged needs to be discussed with the client/patient prior to commencement of treatment thus clearly stipulated within the consent forms. It is important to have a signed contract.
4. Reports can be requested by any of the following: referring doctor/specialist, allied professional, employer, insurance company, patient/client, parent/family or school. The cost of this report needs to be clearly stipulated within the initial consent forms. The cost of the report is not included in the assessment codes' reimbursement and must be billed/coded separately.
5. Code 110 - This procedure may be billed when a motivation report is requested by the funder. No other reports will be paid for by the funder. **This code is for when the OT** has to motivate for therapy, report on assessment results & findings, progress reporting, to provide handover or for pre-authorisation.
6. **Code 111** – This is a new code that is being introduced and carries no units or set monetary value. Thus, indicating that the therapist must indicate in the consent form the cost that is allocated to this code and that it is for the account of the member/client. The funder will NOT reimburse this code as the report has NOT been requested by the funder.

1.2 PROCEDURES OF EVALUATION

- This procedure is essential for identification of problems and the functional implication of the condition as well as the individual abilities of the patient.
- The various evaluation procedures include preparation, recording, interpretation. Some evaluations can be effected in a specific time limit, others may require more time (days) but would not necessarily take up additional treatment time of the patient.
- Evaluation takes place initially but also continues throughout treatment and is utilized for selection, grading and adjustment of treatment procedures/techniques.
- Evaluation of specific abilities and function can broadly be sub-divided into levels from simple to more complex evaluations.
- The interview process and gathering of important collateral information from patient, family and colleagues is not accounted for in the evaluation codes.
- These procedure codes will reflect the level of evaluation for the specific patient
- 200 code is billed to assess the suitability of a client for a group, prior to placement in group programme. HOWEVER, a 201 or any other 200 code may not be billed in addition to a group code, unless clinical notes can indicate time spent with the client PRIOR to the attendance of group. Assessment done within groups is inherent in the group treatment.
- No assessments to be done in group format.
- The examples of standardised assessments used within this document are not an exhaustive list but merely suggestions.

1.2.1 OBSERVATION AND SCREENING

CODE	DESCRIPTION	UNITS
201	Observation and Screening	7.5

GENERAL DEFINITION:

- Generally occurs at the beginning of a session.
- Does not involve hands-on/formal assessment or any treatment intervention

RULES:

1. May be billed with every treatment session as appropriate, in addition to an individual treatment code – particularly with complex patients or if the patient has not been treated for several days.
2. This code may be billed in combination with an interview, guidance or consultation code namely 108 or 109 within their guided frequency. This is dependent on the clinical intervention provided by the OT and supporting clinical documentation.
3. To be recorded in notes

Time guide: 7.5 - 15minutes

NOTES:

Depending on the patient's pathology and/or problems identified, any of the following could be evaluated: Muscle tone, muscle strength, range of movement, aspects of sensation, balance, eye control, primitive postural reflex activity, body awareness, memory (visual, auditory), thought process, concentration, conation, consciousness, affect, insight etc.

The assessment of aspects of physical/mental function would involve the assessment of posture, co-ordination (gross, fine), hand function, mobility, visual-somato-sensory- and auditory perception, visual motor integration, laterality, praxis, interpersonal relationships, reality orientation, mood, creative ability etc.

Within hospital setting, OT's could also review vital functions, medically related symptoms, pain and level of consciousness.

The quality of day to day functioning with regard to personal management, work, play, leisure pursuits and socialisation will form a very important part of all occupational therapy evaluations.

1.2.2 EVALUATION OF SPECIFIC ABILITIES AND FUNCTION TO IDENTIFY THE DEGREE OF THE PROBLEM IN PHYSICAL, PSYCHOLOGICAL AND FUNCTIONAL ASPECTS OF THE PATIENT

CODE	DESCRIPTION	UNITS
203	Specific evaluation for a single aspect of dysfunction (Specify which aspect)	7.5 units

GENERAL DEFINITION:

1. Assesses the **single aspect** of dysfunction related to physical, psycho-social or functioning in everyday activities.
2. Examples of assessments of one element:
    a. Physical - muscle tone / muscle strength / range of movement of a single joint / aspects of sensation / aspects of movement patterns / eye control / balance etc.
    b. Functional – dressing / eating / play / self-care etc.
    c. Perception – figure ground / form constancy / spatial relations / position in space / body concept / body scheme / closure / reception / association / discrimination / analysis / synthesis etc.
    d. Psychiatry – This code is seldom used within this area as it is difficult to only assess single aspect of cognitive or psychological functioning.
    e. Self-report questionnaires such as Oswestry, NDI, Brief Pain Inventory etc.
3. The outcome of the assessment should determine the course of treatment for the day

RULES:

1. May be billed with every treatment session to enable the therapist to briefly assess and compare the results to previously recorded outcomes to determine progress or regression.
2. This code may be billed in combination with an interview, guidance or consultation code namely 108 or 109 within their guided frequency. This is dependent on the clinical intervention provided by the OT and supporting clinical documentation.

Time guide: 7.5 -15 minutes

ADDITIONAL NOTES FOR OT'S WORKING IN PAEDIATRICS:

This code is not often used, but one might use it when looking at only visual-motor integration, or only at figure-ground perception, or only at visual memory etc. for example. Depending on the test rules, only certain assessments can be split up like this. The assessment takes between 5-15 minutes.

Examples of assessments used are:

1. Developmental Test of Visual-Motor Integration (Beery, K.E. and Buktenica, N.A., 1997) – Green or blue form only

2. Detailed Assessment of Speed of Handwriting (Barnett et al 2007)

CODE	DESCRIPTION	UNITS
205	Specific evaluation of dysfunction involving only one part of the body for a specific functional problem (specify part and aspects evaluated)	22.5 units

GENERAL DEFINITION:

1. Assessment of a combination of single aspects of function, which defines the dysfunction of the body part.
2. Examples: Gross motor, fine motor, visual perception, sensory processing/modulation, limb ROM, oedema, muscle strength, sensation, hand function. Standardised tests: CAM, Visual assessment, Fugl-Meyer UL, RBANS, WASPS (one test assessing a number of single aspects), and also perhaps bedside screening tests such as LOTCA, MoCA etc.

RULES:

1. Should not be used more than once a week, however can be validated with motivation in clinical notes for more frequent use.
2. This code may be billed in combination with an interview, guidance or consultation code namely 108 or 109 within their guided frequency. This is also dependent on the clinical intervention provided by the OT and supporting clinical documentation.

Time guide: 20 – 30 minutes

ADDITIONAL NOTES FOR OT'S WORKING IN PAEDIATRICS:

This code would be used when assessing a specific area e.g. a handwriting assessment looks at pencil control, pencil grasp, joint mobility/stability, where the movement is being initiated from etc.

Depending on which visual-perceptual test one uses, they look at figure-ground perception, visual memory, visual-sequential memory, visual closure, spatial relations, visual-motor integration, visual discrimination, motor accuracy etc.

Some examples of assessments used are:

1. Functional Handwriting Assessment (McDougall, B., 2004)
2. Developmental Test of Visual-Motor Integration (Beery, K.E. and Buktenica, N.A., 1997)
3. Test of Visual Perception (Gardener, M.F., 1988)
4. Sensory Profile (Dunn, W., 1999)
5. Sensory Processing Measure™ (Parham, L, D., Ecker, C., 2010)

CODE	DESCRIPTION	UNITS
207	Specific evaluation of dysfunction involving the whole body (specify condition and which aspects evaluated)	45 units

GENERAL DEFINITION:

1. Combination of two or three functional units or a specific standardized assessment

RULES:

1. May be billed once in a three-month period per therapist, as validated within clinical notes based on goals/clinical outcomes set by therapist.
2. This code may be billed in combination with an interview, guidance or consultation code namely 108 or 109 within their guided frequency. This is dependent on the clinical intervention provided by the OT and supporting clinical documentation.
3. Combination of formal and informal tests allowed – time is taken into consideration.

Time guide: 45 – 60 minutes

ADDITIONAL NOTES FOR OT's WORKING IN PAEDIATRICS:

This assessment would be used when assessing specific dysfunction involving the whole body

This assessment excludes report writing, parent meetings and classrooms observations)

Examples of assessments used when billing this code (Please note that only one of these assessments would be used for this code):

1. Miller Assessment for Pre-Schoolers (Miller, L.J., 1988)
2. DeGangi-Berk Test of Sensory Integration™ (DeGangi, G.A., Berk, R,A.,)
3. Clinical Observations of Motor Performance (SAISI, 2005)
4. Movement Assessment Battery for Children – (Barnett, A., Henderson, S, E., & Sugden, D, A., 2007
5. Bayley Scales of Infant and Toddler Development®, (Bayley, N., 2005)
6. Peabody Developmental Scales (Folio and Fewell,1983)

CODE	DESCRIPTION	UNITS
209	Specific in-depth evaluation of certain functions affecting the total person (specify which aspects evaluated)	75 units

RULES:

1. May be billed once in a three-month period per therapist, as validated within clinical notes based on goals/clinical outcomes set by therapist.
2. This code may be billed in combination with an interview, guidance or consultation code namely 108 or 109 within their guided frequency. This is dependent on the clinical intervention provided by the OT and supporting clinical documentation.

Time guide: 60-90 minutes

GENERAL DEFINITION:

1. Combination of four or five functional units or two to three specific standardized assessments, home environment evaluation, ADL evaluation.
2. Combination of formal and informal tests allowed – time is taken into consideration.

ADDITIONAL NOTES FOR OT'S WORKING IN PAEDIATRICS:

This code is used when performing an in-depth evaluation of certain functions affecting the total person. A combination of approximately 4 tests are used and these are considered in relation to the time guide of units allocated to this code (excluding report writing, parent meetings and classrooms observations).

We would assess the following aspects:

- Gross Motor
- Fine Motor
- Visual-perception
- Sensory Integration

Assessment Examples include:

1. Miller Assessment for Pre-Schoolers (Miller, L.J., 1988)
2. DeGangi-Berk Test of Sensory Integration™ (DeGangi, G.A., Berk, R,A.,)
3. Clinical Observations of Motor Performance (SAISI, 2005)
4. Test of Visual Perception (Gardener, M.F., 1988)
5. Developmental Test of Visual-Motor Integration (Beery, K.E. and Buktenica, N.A., 1997)
6. Goodenough-Harris Drawing Test (Harris, D.B.)
7. Functional Handwriting Assessment (McDougall, B., 2004)
8. Sensory Profile (Dunn, W., 1999)
9. Miller Assessment for Pre-Schoolers (Miller, L.J., 1988)
10. Brief Cognitive Assessment Tool Mansbach, W.,)
11. Movement Assessment Battery for Children – (Barnett, A., Henderson, S, E., & Sugden, D, A., 2007
12. Sensory Processing Measure™ (Parham, L, D., Ecker, C., 2010)
13. Bruininks-Oseretsky Test of Motor Proficiency (Bruininks, R, H., &Bruininks, B, D.,2005)
14. Bayley Scales of Infant and Toddler Development®, (Bayley, N., 2005)
15. Detailed Assessment of Speed of Handwriting (Barnett et al 2007)
16. Peabody Developmental Scales (Folio and Fewell,1983)

CODE	DESCRIPTION	UNITS
211	Comprehensive in-depth evaluation of the total person (Specify aspects assessed)	105 units

RULES:

1. May be billed once in a three-month period per therapist, as validated within clinical notes based on goals/clinical outcomes set by therapist.
2. This code may be billed in combination with an interview, guidance or consultation code namely 108 or 109 within their guided frequency. This is dependent on the clinical intervention provided by the OT and supporting clinical documentation.

Time guide: 90-120 minutes

GENERAL DEFINITION:

1. Combination of six or more functional units or four to six specific standardized assessments.
2. Combination of formal and informal tests allowed – time is taken into consideration.

ADDITIONAL NOTES FOR OT'S WORKING IN PAEDIATRICS:

This code is used when performing an in-depth evaluation of the total person. Typically, a combination of at least 3-7 tests are used

We assess the following aspects:

- Gross Motor
- Fine Motor
- Visual-perception
- Sensory Integration

Assessment Examples include:

The list is the same as for the 209 code, but also includes the Sensory Integration and Praxis Test (Ayres, A.J., 2004)

Test Equipment Code: Certain assessments, for example the SIPT have costs associated with scoring them. This is in addition to purchasing the assessment equipment and necessary evaluation forms. The current cost to score a SIPT is about R400 per client, and is depended on the dollar exchange rate. It is suggested this cost is incorporated into practice costing and may be charged under the modifiers. This may be for the cost of the client and should be indicated in the consent form.

1.2.3 MEASUREMENT FOR DESIGNING AND CONSTRUCTING ASSISTIVE DEVICES, SPLINTS OR PRESSURE GARMENTS

CODE	DESCRIPTION	UNITS
213	A static / dynamic orthosis/splint	7.5
217	A pressure garment for one limb (specify)	7.5
219	A pressure garment for one hand (specify)	7.5
221	A pressure garment for the trunk	7.5
223	A pressure garment for the face (chin strap)	7.5
225	A pressure garment for the face (full face mask)	7.5

RULES:

1. The above codes may be used in conjunction with codes 201 – 211 as appropriate.
2. These codes are billed per item that is measured for the body on the same day, indicating whether a splint and/or combination of pressure garment/s is to be made i.e. a client may be measured for a dynamic and a static splint as well as a pressure garment/s.
3. Should the patient require two of the same splints, one for each hand, specify which limb is being measured in your notes as well as on your billing. Therefore, there will only be one measurement pattern done per limb with each splint design. In clinical practice a double set of pressure garments are made but note there will only be one measurement done.

1.3 PROCEDURES OF THERAPY

After a patient has been evaluated, treatment aims are formulated and a programme planned. All therapy is aimed at the improvement of day to day functioning and is effected by means of participation in activity/occupation. By selecting, grading and adapting of appropriate activity, the occupational therapist can effect an integrated treatment programme where more than one identified problem can be treated simultaneously.

Treatment is facilitated by the use of various techniques together with or in preparation for participation in activity. Activities used will reflect those found in everyday life, i.e. personal management activities, work activities, children's play activities, leisure pursuits and socialisation.

1.3.1 TREATMENT IN GROUPS:

- A 200 code is billed to assess the suitability of a client for a group, **prior** to placement in a group programme – please see 200 codes for reference. A **201 or any other 200 code may not be billed in addition to a group code,** assessment done within groups is inherent in the group treatment.
- Medical aids may request an explanation of groups as well as detailed group programme.
- A combination of codes 301,305 & 308 may be billed on one day per group programme. However please note due to the duration of a 308 group (90 minutes), this code **may ONLY** be charged **once** per day.
- Must adhere to descriptions in guidelines.
- Group members should all sign an attendance register or ensure there are comprehensive clinical notes detailing attendance of the group based on signed consent forms.
- Daily clear feedback/process notes should be kept for each client
- Time includes notes and preparation
- Clients may NOT be left on their own during group sessions.
- Tea breaks may be incorporated but if the session continues afterwards, it is still the same session and can only be billed once.
- **Consumables/activities to be charged separately for patient cost under the Annexures for modifiers 0010, 0008 or 0009 may not be covered by Medical Funders**

CODE	DESCRIPTION	UNITS
301	Group treatment in a task-centred activity, per patient (treatment time of 60 minutes or more) *Treatment time: 60 minutes or more*	10 units

GENERAL DEFINITION:

1. The code is defined by many clients working simultaneously either on the same or different activities for a stretch of time
2. The patients may be supervised by an OTA or OTT ("Supervision being defined as assisting where client is unsure of the next steps to follow)
3. Setting is generally in a large recreation / workshop / craft area where each patient is working on his or her own or in pairs
4. The patients' participation is graded and adapted to achieve the planned aims for each individual

RULES:

1. Different group codes may be used on one day provided each group session is specified
2. Combination of group codes, to a maximum of three codes can be billed per day, depending on the holistic therapy programme, which often include group therapy sessions by other disciplines.
3. A client is ONLY billed once for attendance of a group, despite whether there may be more than one OT or an OTT/OTA in a group.

ADDITIONAL NOTES FOR OT's WORKING IN PSYCHIATRY:

1. A maximum of 20 patients (selected by the OT) present in an area, involved in an activity (selected by the OT).
2. OT liaises with the OTA/OTT – Group is presented by an additional OT or OTA / OTT only. OT is on site to supervise OTA/OTT and deal with emergencies if required.
3. No time limit – the clients work until completion of activity. OTA / OTT is present for duration of group.

For example: sport, craft.

4. Reference: Finlay, L. Groupwork in Occupational Therapy. 1993. Chapman & Hall. P126
5. **Note: No codes/billing is allocated for the time of the OTT/OTA**

CODE	DESCRIPTION	UNITS
303	Placement of patient in an appropriate treatment situation requiring structuring the environment, adapting equipment and position the patient.	15

GENERAL DEFINITION:

1. Once the patient has been set up with his/her task, the therapist will move on to the next patient, in this way monitoring the treatment of a number of patients. It is recommended that no more then 2-3 patients be set up in this manner.
2. This code may be used in a group setting where individual needs vary for different patients in a group, for each group treatment situation, therefore the therapist is required to structure a situation for each specific patient.

RULES:

1. This code may be billed in addition with any other group code but needs to be validated in notes.
2. This code may be billed in conjunction with 309 – 319 (individual, undivided attention) dependent on the amount of time that the therapist spends with the patient in an individual capacity, if any. Individual, undivided attention is required when the patient requires additional, individual attention during the session, to ensure progress with his/her task.
3. This code is not appropriate to be used in a home visit treatment situation as this requires individual and undivided attention.
4. Not indicated for group therapy where group dynamics and interaction are utilised.

NOTES:

1. This code does not require individual attention for the whole treatment session, per patient.
2. No stipulated time frame – recommended 15-60 minutes

CODE	DESCRIPTION	UNITS
305	Groups directed to achieve common aims per patient *Treatment time: 60 minutes or more*	20

GENERAL DEFINITION:

1. This is a group where the OT sets specific aims for the group and actively facilitates during the group.
2. The whole group is a unit and directed to achieve a specific aim.
3. The therapist may try to facilitate awareness / contact / interaction between the clients present)

RULES:

1. Different group codes may be used on one day provided each group session is specified
2. Combination of group codes, to a maximum of three codes can be billed per day, depending on the holistic therapy programme, which often include group therapy sessions by other disciplines.

NOTES FOR OT's WORKING IN PSYCHIATRY:

1. Number of participants should be limited depending on the aims of the group, no more than 12 participants. **If more than 12 patients in group, ensure an additional OT is in the group or use 303 code**. **If there is more than one OT, the billing is split evenly between the number of participants in the group e.g. 6 per OT.**
2. Clients are selected; individual needs may vary
3. An ACTIVITY is selected for the group, using activity analysis, adaptations are made, client is structured and ACTIVITY is presented on client's level.
4. The therapist may try to facilitate awareness / attention / ability to follow instructions / task concept / relaxation / contact / interaction between the clients present

CODE	DESCRIPTION	UNITS
307	Simultaneous treatment of two to four patients each with specific problems, utilizing individual activities, per patient *Treatment time: 60 minutes or more*	20

RULES:

1. Different group codes may be used on one day provided each group session is specified

NOTES:

1. These are patient centred groups
2. At times, patients may be grouped together in order to help them solve shared problems or to provide a therapeutic procedure for their specific problem

ADDITIONAL NOTES FOR OT's WORKING IN PAEDIATRICS:

1. Fine motor groups: 2-4 children. Purpose of the group is to strengthen forearm, wrist, hand and finger muscles. The children generally engage in the same activities during each session. There is a short warm-up activity, main activity and closure and homework given. Depending on whether it is an open or closed group, the group process is between 8-30 weekly sessions.
2. Alert group: 2-4 children. Purpose of the group is to improve the child's ability to self-modulate. There is a short warm-up activity, main activity and closure and homework given. The group process is between 8-12 weekly sessions.
3. Gross motor group: 2-4 children. Purpose of the group is to strengthen neck, shoulder girdle, core and pelvic girdle muscles. The children generally engage in the same activities during each session. There is a short warm-up activity, main activity and closure and homework given. Depending on whether it is an open or closed group, the group process is between 8-30 weekly sessions.
4. This code is generally not used within Psychiatry but can be applied should the description of code 307 specifically apply.

CODE	DESCRIPTION	UNITS
308	Simultaneous treatment of two or four neuro- behavioural and stress related conditions or severe head injury patients each with specific problems utilizing individual activities *Treatment time: 90 minutes or more*	30 units

RULES:

1. Different group codes may be used on one day provided each group session is specified

NOTES:

1. These are patient centred groups
2. At times, patients may be grouped together in order to help them solve shared problems or to provide a therapeutic procedure for their specific problem

ADDITIONAL NOTES FOR OT's WORKING IN PSYCHIATRY:

1. In definition, similar to 307, but time span of group is 90 minutes or more (more skills are required from the therapist to facilitate interaction and group dynamics over a longer time period). OT is present for the duration of group.
2. The whole group is a unit and directed to achieve a specific aim for all clients present in the group: aims are for the whole group and for individual needs; therefore the OT is working on 2 levels simultaneously.
3. An ACTIVITY is selected as a means to reach the aims.
4. The correct group procedures are followed with a warm-up, activity and discussion followed by a closure.
5. Throughout the group, the therapist facilitates interaction between the group members, and makes use of curative factors and group dynamics to facilitate healing and progress, and each client's treatment aims are reached individually.
6. The group milieu is INTENTIONALLY facilitated and the therapist makes use of the group to reach aims - it is NOT a case of many clients doing the same activity.
7. Simultaneous treatment with 4-12 clients utilizing individual activities, per patient or a specific selected group activity. For less than 4 members, code 305 can be used and more than 12 members a 301 code is suggested.
8. Group protocols & programmes may be requested to validate allocation of group codes

1.3.2 INDIVIDUAL AND UNDIVIDED ATTENTION DURING A TREATMENT SESSION

The situation might require special handling techniques or specially graded treatment programmes. These individual treatment sessions could last anything from fifteen minutes to approximately two hours. A severely affected young child might only be able to tolerate a fifteen-minute treatment session, whereas, a home visit to stroke patient might last about two hours depending on the nature of the occupational therapy.

The code allocated is dependent on time spent one on one with a client. Treatment may be done in the therapist's rooms or at the patient's home or work. This may include the fitting and alteration of pressure garments, adaptation to previously made splints or assistive devices. It may be necessary to visit a patient from time to time to check whether he is coping in the situation and to adapt or grade the tasks in which he has been placed i.e. at work or in the home.

CODE	DESCRIPTION	UNITS
309	On a level one (10 - 15 minutes)	10
311	On a level two (20 - 30 minutes)	20
313	On a level three (35 - 45 minutes)	30
315	On a level four (50 - 60 minutes)	40
317	On a level five (70 - 90 minutes)	50
319	On a level six (100 - 120 minutes)	60

RULES:

1. Individual and undivided attention during a treatment session utilizing specific activity and/or techniques in an integrated treatment session
2. May be billed in conjunction with 301,305,308, i.e. may be billed in addition to a group code if an individual session is also conducted on the same day.
3. May be billed in conjunction with 303, dependent on the amount of time that the therapist spends with the patient in an individual capacity, if any. Individual, undivided attention is required when the patient requires additional, individual attention during the session, to ensure progress with his/her task.
4. Acute rehab units or settings – patient may be seen twice per day. Separate time related codes to be billed – NOT ACCUMULATED. Essential that the time of treatment is indicated on account to not appear as duplicate billing.
5. Time of treatment provided must be to the maximum units allocated and the time indicated is a guide.

1.4 PROCEDURES REQUIRED TO PROMOTE TREATMENT

1.4.1 RECOMMENDATIONS

CODE	DESCRIPTION	UNITS
401	Recommendations with regards to assistive devices, environmental adaptations, alternative / compensatory methods, handling the patient *Time guideline: 7.5 – 15minutes*	15

RULES:

1. May be billed after the treatment session when providing with specific recommendations or instructions until next treatment session. May only be billed once daily.
2. Can include generic or short home programmes
3. If advice giving is greater than 15 min, code 108 should be billed
4. This code may **NOT** be used to bill for practice or craft consumables nor for any assistive devices/splints or pressure garments. This is billed when recommendations are made to various persons including the patient as per the description

1.4.2 DESIGNING AND CONSTRUCTING A CUSTOM-MADE ADAPTATION, ASSISTIVE DEVICE, SPLINT OR SIMPLE PRESSURE GARMENT FOR TREATMENT IN A TASK-CENTRED ACTIVITY (SPECIFY THE ADAPTATION, ASSISTIVE DEVICE, SPLINT OR SIMPLE PRESSURE GARMENT)

CODE	DESCRIPTION	UNITS
403	On a level one	10
405	On a level two	20
407	On a level three	30
409	On a level four	40
411	On a level five	50
413	On a level six	60
415	Designing and constructing a static orthosis	60
417	Designing and constructing a dynamic orthosis	120

RULES:

1. Should a splint be very small and take between 15 and 30 minutes to manufacture, it should still be billed under a code 403 – 405
2. Training in the use and care of a splint should be charged under code 309 – 319 (Individual treatment)
3. Take note: these codes are NOT related to the code 401 and are not for recommendations but the actual design or adjustment per item as described in the description

CODE	DESCRIPTION	UNITS
Designing and constructing pressure garment for:		
419	Limb	60
421	Face (chin strap only)	45
423	Face (full face mask	60
425	Trunk	90
427	Hand	90

RULES:

1. The whole body or part thereof will be the sum total of the parts for the first garment and 75% of the fee for any additional garments made on the same pattern for the same patient
2. Fitting the pressure garment and instruction in the wear and care of the garments should be billed with the appropriate individual billing code (309 – 319)

SUGGESTED GARMENTS RELEVANT TO ABOVE DESIGN & CONSTRUCTION CODES:

1. 419 – finger sock (818) / gauntlet (803) / upper limb (804, 805) / lower limb (808, 809, 810)
2. 421 – chin strap (815)
3. 423 – full face mask (812)
4. 425 – sleeveless vest (807) / knee length sock (813, 814)
5. 427 – glove (801)

1.4.3 PLANNING AND PREPARING AN IN-DEPTH HOME PROGRAMME

CODE	DESCRIPTION	UNITS
431	Planning and preparing an in-depth home programme on a monthly basis	90
RULES: 1. This should only be used when a ONE MONTH programme has been provided to the patient 2. Shorter revisions or reviews to the programme should be billed under different billing codes e.g. 401, 108		

1.4.4 HIRING EQUIPMENT

CODE	DESCRIPTION	UNITS
434	1% of the current replacement value of the equipment may be charged in one day.	**90**
RULES: 1. Total charge may not exceed 50% of replacement value. 2. Description of equipment should accompany accounts. 3. Usually not paid for by medical schemes.		

2. VISITING CODES

These codes were not included in the NHRPL 2006 which is the version legally referred to within the Health Industry. They are however included in the NHRPL 2009 and are currently accepted by majority of Healthcare Funders.

CODE	DESCRIPTION	UNITS
501	Treatment in a nursing home or other healthcare facility	10
503	Domiciliary visit	20

RULES:

1. This fee is charged when a treatment session is conducted in a facility/home.
2. This is at the discretion of the therapist if travelling time is included.
3. It is permitted to charge 0011 as well as 503/ 501.
4. Clinical procedural code needs to be added to this.
5. These codes may not be reimbursed by schemes.

III. MODIFIERS

1.1 EMERGENCY / AFTERHOURS WORK

CODE	DESCRIPTION
0006	Add 50% of the total cost for the procedure.

GENERAL DEFINITION:

Where **emergency treatment** is provided:

a) During working hours, and the provision of such treatment requires the practitioner to leave his or her practice to attend to patient in hospital or

b) After working hours

c) **NOTE:** This **MAY NOT** be charged when weekend treatment is provided as clinical care – ONLY when an emergency intervention is requested or require per medical condition

For the purposes of this rule:

a) "emergency treatment" means a bona fide, justifiable emergency occupational therapy procedure, where failure to provide the procedure immediately would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in jeopardy; and

b) "Working hours" means 8h00 to 17h00, Monday to Friday.

1.2 ASSISTIVE DEVICES

CODE	DESCRIPTION
0008	Assistive devices to be charged (exclusive of vat) at net acquisition price plus - 26% of the net acquisition price where the net acquisition price of that appliance is less than one hundred Rand - A maximum of twenty-six Rand, where the net acquisition price of that appliance is greater than or equal to one hundred Rand

ASSISTIVE DEVICES MADE BY THERAPIST TO BE USED WITH MODIFIER 0008	
1001	Hip abduction cushion
1002	Sponge on a stick
1003	Hand grips (for utensils)
1008	Wheelchair strap

Please note the following are not often made by OT's and may be purchased commercially:

1004	**Bath bench**
1005	**Bath seat**
1006	**Transfer board**
1007	**Plate surround**

FURTHER RESEARCH NEEDS TO BE DONE INTO ADDITIONAL ASSISTIVE DEVICES THAT COULD BE MADE BY AN OT

1.3 MATERIALS USED IN THE CONSTRUCTION OF ORTHOSES AND PRESSURE GARMENTS

CODE	DESCRIPTION
0009	Materials used in the construction of orthoses or pressure garments shall be charged (exclusive of vat) at net acquisition price plus - 26% of the net acquisition price where the net acquisition price of that material is less than one hundred Rand - A maximum of twenty-six Rand where the net acquisition price of that material is greater than or equal to one hundred Rand
RULE: Modifier 0009 must be quoted after the appropriate code numbers (403 to 427)	

CODES AND DESCRIPTIONS OF SPLINTS TO BE USED WITH MODIFIER 0009	
701	Static finger extension/flexion splint
702	Dynamic finger extension/flexion
703	Buddy strap
704	DIP/PIP flexion strap
705	MP, PIP, DIP flexion strap
706	Hand based static finger extension/flexion
707	Hand based static thumb extension/flexion/opposition/abduction
708	Hand based dynamic finger flexion/extension
709	Hand based dynamic thumb flexion/extension/opposition/abduction
710	Static wrist extension/flexion
711	Dynamic wrist extension/flexion
712	Flexion glove
713	Forearm based dynamic finger flexion/extension
714	Forearm based dorsal protection

715	Forearm based volar resting
716	Static elbow extension/flexion
717	Dynamic elbow flexion/extension splint
718	Shoulder abduction splint
719	Static rigid neck splint
720	Static soft neck splint/brace
721	Static knee extension
722	Static foot dorsiflexion

CODES AND DESCRIPTIONS OF PRESSURE GARMENTS TO BE USED WITH MODIFIER 0009	
801	Glove to wrist
802	Glove to elbow
803	Gauntlet (glove with palm and thumb only)
804	Sleeve: upper/forearm
805	Sleeve: full
806	Vest + sleeves
807	Sleeveless vest
808	Upper leg
809	Lower leg
810	Full leg
811	Pants (trunk and full legs)
812	Briefs
813	Anklet
814	Knee length stocking

815	Chin strap
816	Full face mask
817	Neck only
818	Finger sock

1.4 MATERIALS USED IN TREATMENT

CODE	DESCRIPTION
0010	Materials used in treatment shall be charged (exclusive of vat) at net acquisition price plus - 26% of the net acquisition price where the net acquisition price of that material is less than one hundred Rand - A maximum of twenty-six Rand where the net acquisition price of that material is greater than or equal to one hundred Rand

LIST OF MATERIALS USED IN TREATMENT WITH MODIFIER 0010	
901	Therapeutic putty
902	Wood, leather, sisal
903	Sponge
904	Elastonet
905	Silicone Gel
***906**	*Simple craft activity - value*

**This is a suggested modifier to be used AND may not be reimbursed by the funders. This may be for the account of your patient.*

1.5 TRAVEL COSTS

CODE	DESCRIPTION
0011	Travelling costs according to AA rates
RULE: Where the therapist performs treatments away from treatment rooms, travelling costs to be charged according to AA rates e.g. domiciliary treatments or treatments in nursing homes. Modifier 0011 must be quoted after appropriate code numbers. Please note that although some medical schemes accept responsibility for the payment of transport expenses, others do so in exceptional cases only.	

1.6 SERVICES RENDERED IN A HOSPITAL

CODE	DESCRIPTION
0021	Services rendered to hospital inpatients
RULE: Modifier 0021 must be quoted on all accounts for services performed on hospital inpatients.	