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Annexure E

PRINCIPLES AND GUIDELINES FOR ESTABLISHING AND MAINTAINING AN EFFECTIVE MEDICAL CODING SYSTEM IN SOUTH AFRICA

1. OBJECTIVES OF A COMPREHENSIVE CODING SYSTEM

To provide a uniform language that comprehensively describes medical, surgical and diagnostic services as well as allied discipline services. The coding system should serve as a reliable means for national and private sector communications amongst all healthcare professionals, patients, funders, administrators, statutory bodies and other stakeholders.

2. WHY HAVE A CODING STRUCTURE AND A REFERENCE PRICE LIST?

The publication of an approved and structured coding structure and a resulting reference price list has a profound effect on the healthcare profession and patients.

- Whilst a reference price list purports to be non-binding it "de facto" determines the levels of scheme reimbursements and a description of services delivered.
- There is a need to provide a standardised coding and tariff structure.
- There is a need to generate an understanding of actual costs of healthcare services in South Africa as well as the nature of services delivered.
- There is a need to protect the interests of medical scheme beneficiaries. Patients need certainty as to reimbursement by medical schemes.
- New medical technology in terms of procedures and clinical practice is continually being developed and needs to be incorporated and reflected in Healthcare Professional (HCP) billing and tariff structures. Without appropriate billing codes these new procedures and techniques cannot find their way into serving patients.

3. CURRENT STATUS OF THE SOUTH AFRICAN MEDICAL ASSOCIATION (SAMA) DOCTORS BILLING MANUA (DBM) AND MEDICAL CODING IN SOUTH AFRICA

Following the Competition Commission rulings in 2003 there has been limited formal interaction between stakeholders in the development and changes to the Doctors Billing Manual as maintained by South African Medical Association (SAMA). The National Health Reference Price List (NHRPL) published by Council for Medical Schemes (CMS) for 2004 – 2006 is in essence the 2003 Board of Healthcare Funders (BHF) tariff list and includes no changes and/or updates for the past 10 years. The NHRPL 2006 is therefore incomplete and should not be used by the HPCSA to set guideline tariffs.

SAMA has effected limited updates to the DBM for the period 2004 – 2009 and the last hard copy of a DBM was published in 2009. SAMA subsequently released an electronic version of its DBM, but this version is not complete as to rules and interpretations and is not widely accessible, nor user friendly.

There are currently virtually no interactions or processes in place that allows for an in depth discussion between SAMA and the Funding industry prior to the implementation of new codes, changes to codes or the deletion of codes.

The result is that there are major discrepancies between the SAMA DBM and the coding and tariff structures as maintained by Funders and Administrators. This causes uncertainty between doctors and patients as there is confusion as to whether a procedure is covered by a funder, or whether it will be reimbursed. This situation is unacceptable and requires urgent remedial action.

During 2010 and 2011 SAPPF initiated an engagement process with Medical Schemes and Administrators whereby changes to coding were discussed with stakeholders in the industry. The process was transparent and fully documented. This process continued in 2012.

In addition, research into the coding structure for medical practitioners as contained in the DBM indicates certain shortcomings:

- It is not comprehensive in that not all interventions performed by each discipline are listed. These omissions are often corrected by applying a modifier, to an equivalent code.
- These inconsistencies and loop holes allow unbundling of codes in certain disciplines.
- The current coding structure is not amenable to perform accurate statistical analyses.
- Code numbers do not follow a consistent hierarchical structure.
- The 2012 & 2013 changes to the DBM by SAMA did not follow the customary rigorous Specialist Peer Review procedures. SAMA also did not consider comments by other stakeholders.

In order to rectify these and other shortcomings, a sweeping revision of the classificatory system, the code numbers and associated descriptor terminology is required. Such a revision needs to be carried out within a new governance structure.

4. THE CODING GOVERNANCE STRUCTURE REQUIRED FOR SOUTH AFRICA

It is imperative and urgent that an independent multi-stakeholder non-profit organisation (NPO) be established to manage the governance processes related to all coding systems in South Africa. Such an entity must be free of any political or other interference.

The NPO will not "own" codes; nor will it commercialise codes. It will assist with and manage processes related to the implementation and management of coding systems. In this regard the South African Private Practitioners Forum (SAPPF) has facilitated the establishment of a NPO, South African Classification of Healthcare Interventions (SACHI).

The basic SACHI concept has been discussed with most stakeholders and they are agreeable that this is the way forward. Detailed governance structures are being developed.

5. CANDIDATE CODING SYSTEMS FOR SOUTH AFRICA

The various alternatives under consideration in South Africa are:

5.1 Australian Classification of Health Interventions (**"ACHI"**)

5.2 International Classisfication of Health Interventions (**"ICHI"**)

5.3 Australian Medicare Benefit Schedule (**"MBS"**)

5.4 Classification des Actes Medicaux (**"CCAM"**) – France

5.5 USA Centre for Medicare and Medicaid (**"ICD-10 PCS"**)

5.6 Physicians' Current Procedural Terminology (**"CPT4®"**) – American Medical Association (**"AMA"**)

5.7 Modified SAMA Billing Codes – DBM

Evaluating these alternatives is still under way and, with the exception of a modified SAMA structure, is unlikely to be implemented before 2015.

The Physicians' Current Procedural Terminology (CPT4®) five digit numeric codes, descriptions, numeric modifiers, instructions, guidelines and other material are copyright of the AMA. Complete CPT® for SA (CCSA) is the subject of copyright owned by SAMA. No fee schedules, basic unit values, relative value guides, related lists, conversion factors or scales are included in CPT4®. Certain stakeholders are concerned with the trademark attached to CPT4®. This constraint however has not been investigated, making an earlier solution possible. It should be noted that many administrators, schemes and hospitals utilize CPT4® in their daily management and billing. CCSA (CPT4®) has also been adopted by other surgical disciplines in coding and billing arrangements with certain medical aids.

Modified SAMA Billing Codes includes a total review of existing SAMA Codes and cross referencing these to CPT4® codes and RVUs.

6. REFERENCE PRICE LIST (RPL) COMPONENTS

The RPL requirements can be categorized into four distinct areas:

- The **coding structure,** which includes the code number and the terminology or nomenclature that is associated with a specific number or concept. NHRPL 2006 is deficient in this regard in that not all codes are included.
- The **relative value** (RVU) of each of the concepts, which has been prescribed to be based upon the average time taken to perform the health care intervention associated with the concept. The average duration may be weighted by a responsibility factor that will cause concepts, which, for example, have a higher complexity or require more skill to have a higher relative value. NHRPL 2006 RVUs have not been reviewed or updated for 10 years and can therefore not be relied upon.
- The **Rand Conversion Factor** (RCF) which represents an average cost per minute and is calculated by taking into account the cost of the resources required to perform a health care intervention, including the professional income of the health care professional. The reference price of each of the items in a schedule is determined through a multiplication of the RVU of each concept by the RCF. The RCF needs to be scientifically determined and cannot merely be a random number that is selected. The NHRPL 2006 can therefore not be used as a basis for a RPL as it includes no costing data nor does it motivate why differential RCFs are used for consultation and procedure codes.
- The **costing spreadsheet** through which the relative value units, the Rand conversion factors and, ultimately, the reference price per concept is calculated. Of importance in this regard is that the total duration of all the interventions that are estimated to be performed by a health care provider has to balance back to that health care provider's standard volume of time. Similarly, the total estimated revenue has to balance back to the total input costs, including the professional remuneration of the healthcare professional and a return on investment. The NHRPL 2006 includes no such costing spreadsheet, nor has the HPCSA indicated how they intend to deal with this important component of a RPL.

In order to constitute a complete RPL, specific requirements have to be fulfilled with respect to each of these aspects.

7. CODING STRUCTURE

The list of items or concepts within the coding structure must comply with a number of general requirements:

- Comprehensive. The list should provide all the recognized interventions (accepted practice) that are offered by the HCP group to which it is applicable.
- Consistent. There should be no duplication or overlap between the items in a list.
- Systematic. The list should reflect basic organizing concepts used by the provider group, such as anatomical regions and/or treatment modality.

8. MODIFIED SAMA CODING SYSTEM

A number of specialist societies have endeavoured to improve and maintain their specialist coding structures based on international practices over the last decade. It is therefore possible to present a coding structure that is Comprehensive, Consistent and Systematic.

The following societies have in recent years updated their coding structures and initial proposals were made to restructure code numbering.

- The South African Society of Otorhinolaryngology, Head and Neck Surgery (ENT Society)
- The South African Society of Obstetrics and Gynaecology (SASOG)
- Urology Society of South Africa (UROSA)
- Ophthalmology Society of South Africa (OSSA)
- South African Paediatric Association (SAPA)
- South African Society of Psychiatrists (SASOP)

9. ADOPTION OF CPT4® CODING SYSTEM

The coding systems employed by a number of surgical societies require a major review. It was therefore decided to adopt the CPT4® system. The following societies have approved this approach:

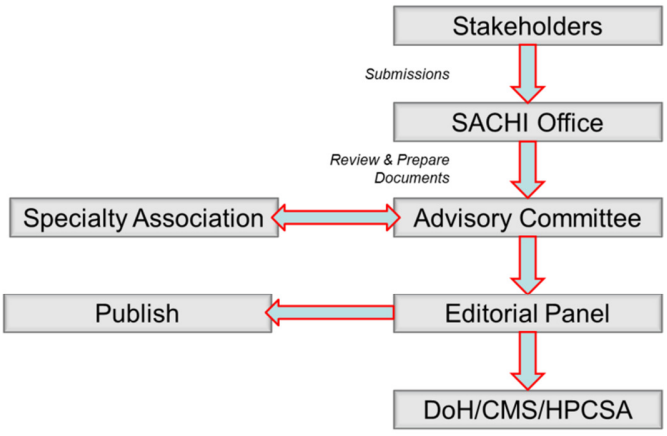
- Association of South African Surgeons (ASSA)
- South African Society of Gastroenterology (SAGES)
- Neurosurgery Society of South Africa
- Association of Plastic and Reconstructive Surgeons of Southern Africa (APRSSA)

It is worthwhile noting that ASSA and SAGES have successfully implemented CPT4® with Medihelp and have done so for the past eight years.

10. PROCEDURES FOR ADDITIONS, DELETIONS OR CHANGES TO FEE ITEMS

10.1 Submission of Code Changes:

Code proposals can be submitted to SACHI/SAMA by national professional associations, specialty societies (through the appropriate national professional associations) national regulatory agencies, medical schemes, medical scheme administrators, managed care organisations and other organisations. Such changes need to be subjected to the necessary review and governance processes discussed in this section of the submission. The process flow is set out below.



10.2 Guidelines for Code Changes:

Change requests include revisions, additions and deletions. Revision requests may be submitted at any time. All revision requests received will be considered for inclusion in updated versions of the RPL Schedules. These updates should ideally be done every 6 months. The deadline for addition and deletion requests for the next annual RPL Schedules should be 30th May of each year. This will allow Medical Schemes time to include such changes in their benefit rules and budgets for the following year.

Interdisciplinary relativities and overlap codes (codes used by more than one discipline) will require research and adjustment according to predefined norms. A basket of common, representative codes and activities will be maintained in a detailed activity costed reference database. This database should cover all surgical and consulting disciplines and will comprise approximately 300 codes.

10.3 A procedure/service code consists of the following components:

a. Schedule: A schedule contains the price list items applicable to one or more provider groups.
b. Provider Group: A professional group or sub-group (discipline, sub-discipline) or health service provider category to which a particular schedule applies.
c. Item Code: A five digit numeric code that is unique to a particular schedule. Numeric codes to be updated in line with international structures that will facilitate improved statistical analysis.
d. Item Type: A one-letter field used to indicate whether the item is an actual service item, or a modifier, note or rule relating to the use of one or more service items.
e. Item Terminology/Nomenclature: A brief written definition of the price list item. Each item must be described using a standardized terminology.
f. Descriptor: A written narrative that provides further definition and the intended use of the item. A descriptor is optional.
g. Relative Value Unit (RVU): A numeric value that expresses the value of this item relative to all the other items in the schedule. A RVU is multiplied by a Rand Conversion Factor (RCF)

to obtain the price of the item. RVUs can vary by provider group for each item in a schedule.

h. Benefit Factor. In general all items in a reference price list will have a benefit factor of 1. Healthcare funders may negotiate with individual health care providers to vary this factor in order to reimburse by agreement either above or below the reference price for an item. As an example, the Bonitas Medical Scheme Payment arrangement benefit factor is 1.3, based on the current scheme rate.

i. Liability Factor. This will be a rating according to medico legal risk and cost, so as to recover professional indemnity insurance costs.

j. Geographic Factor. A rating according to the area of use, general or sub-specialty or a centre of excellence.

k. Experience Factor. A rating according to the experience of the medical doctor. This will for example be 1 for a new doctor, 1.25 for 5 years' experience and 1.5 for 10 years plus experience.

10.4 The following guidelines should be followed when submitting change requests. Any requests that do not meet these guidelines are not likely to receive favourable consideration during the evaluation process:

a. A suggested procedure/service should be a distinct service that is part of current clinical/technical practice (i.e. that the proven clinical efficacy has been established and documented) and is not now included in the relevant Schedule. The procedure/service should be cross referenced to an existing CPT4® code and be supported by the necessary clinical literature.

b. The frequency of occurrence of the procedure/service should be estimated when submitting a request. The suggested procedure/service should be performed across the country in multiple locations and by many providers (per discipline) as the Schedules are not intended to accommodate procedures that are delivered on an infrequent basis. Estimated utilization and the financial impact thereof should be based on medical scheme utilization statistics.

c. A suggested service/procedure should be neither a fragmentation of an existing procedure/service nor currently reportable by one or more existing codes;
d. A suggested service/procedure should not be requested as a means to report extraordinary circumstances related to the performance of a procedure/service already having a specific code;
e. A suggested revision should address omissions or ambiguities within a current procedure/service code's terminology or descriptor;
f. A suggested deletion should address a procedure/service that is no longer considered current or acceptable clinical/technical practice;
g. The Professional Organisations' "Acceptance" or "Approval" programmes shall not be the sole basis on which a procedure code is added. It must withstand peer review by other specialist societies and stakeholders in the funding industry.
h. Previously submitted but not accepted change requests must be accompanied by new information in order to be reconsidered;
i. A suggested Relative Value Unit / RPL Rate should include all information and address all aspects to be considered in determining a RVU/Rate.

10.5 Evaluation Criteria

Requested changes to the RPL Schedules are evaluated by the SACHI Advisory Committee (AC), a body that has multi-stakeholder representation appointed by the SACHI Board of Directors in terms of its Memorandum of Incorporation. Requests for additions, revisions or deletions that meet the submission Guidelines noted here above are also evaluated by the AC using additional criteria that include the following considerations:

a. Is the procedure/service currently taught in an accredited training school, or in an accredited post-graduate programme?
b. Is the procedure/service currently accepted therapy?
c. Does the procedure/service apply to treatment provided by generalists and specialists without differentiation?
d. Does the procedure/service endorse or reflect a product-specific technique?

The goal of the evaluation process is to maintain the best possible RPL Schedules. These would be code sets that includes only those procedures needed to adequately maintain patient records and to support claim submissions.

Information provided in a 'vignette' assists in the evaluation of requests for additions or revisions. A 'vignette' provides a description of the typical patient and the clinical procedure as performed by the practitioner, as well as whether it is appropriate to report the procedure with any others. For a stand-alone procedure/service the 'vignette' should note which other procedures must be reported at the same time, and which must not.

10.6 Instructions for submitting code changes:

Consider the following when completing either version (addition, revision, deletion) of the request:

a. A separate request is required per code for each desired action related to the code.
b. Provide substantive justification for proposing the request. Please avoid reasons such as "no code currently available."
c. Include vignettes, if helpful. A vignette must include the following information:
   Description of the typical patient for whom the procedure is used. Description of the clinical procedure itself. An indication whether it is appropriate to report the procedure with any others.
d. For a stand-alone procedure a note on other procedures that must be reported at the same time, and those which must not.
e. When requesting a new procedure code that represents new technology, attach available supporting peer-reviewed literature.
f. Attach literature, when available, indicating widespread usage and acceptance of the procedure.

g. When requesting a deletion, provide an alternate code that is not an unspecified code for reporting the procedure. If there is no alternative or the procedure is believed to be obsolete, express this in writing.
h. All submissions must be submitted on a prescribed submission form. This form needs to be developed with input from all stakeholders.

10.7 A suggested Relative Value Unit /RPL Rate must include the following information:

a. Time (Unit Value):
b. Indicate the average time required (expressed in minutes) to perform all steps necessary to complete the defined procedure once. Use the following as guideline and indicate the time required per category as indicated:
c. Clinical time refers to the time required to complete the actual procedure/service, as well as pre-, inter- and post- procedural activities for which no other distinct procedure codes exists.
d. Distinct procedures are other independent procedures that are reported in addition to this code. For example, preparing a surgical site and the changing of instruments needed to render the procedure/service are considered clinical time. The time required to obtain anaesthesia before the procedure can commences, is however excluded if local anaesthesia is reported in addition to this code.
e. Assistant time, also known as aide time, includes the mixing of materials, developing of radiographs, etc.
f. Clerical time includes recording the procedure on the patient's record and if applicable, converting the clinical findings to a meaningful report.

10.8 Responsibility (Responsibility Value):

Indicate the responsibility to provide the procedure/service. The following must be considered:

a. Experience and knowledge: The actual observation or practical acquaintance required to provide the service. This is analogous to the level of education or training required to provide the service.
b. Judgment and mental effort: The mental exertion or striving involved in the formation of an opinion or notion concerning the provision of the service.
c. Skill and physical effort: The ability, competence, technique, and physical exertion or striving required to provide the service.
d. Risk and stress to the patient: The clinical and technical risks involved to the patient, as well as the strained effort and demand on physical and mental energy on the patient receiving the service (and thus also the medico-legal risk to the practitioner in providing the service).
e. Example: Select a current procedure/service as the "experience standard" for a discipline and plot on the scale. The "experience standard" should be a procedure/service which is rendered by the 'average' practitioner; for the 'average' patient; simple (unaccompanied by complications); frequently performed, and limited in variation of technique. It will be useful if Specialists compile a benchmark list of approximately 100 procedure codes against which new submissions can be evaluated.
f. Indicate other current and similar procedure codes with which this procedure relates (if any).

10.9 Equipment and Materials:

a. An indication of the equipment and materials) required to provide the procedure.
b. An indication of the cost of the equipment and material(s) to provide the procedure.
c. An indication if the equipment used are considered as "standard equipment" for a "standard practice" within the discipline.

10.10 Location and Other Services:

a. An indication if the procedure is provided in the Health Care Professional's (HCP) own practice, hospital, etc. or both. An adjustment would have to be made where the HCP is a Public Sector employee and uses Public Sector facilities to render the service.
b. An indication if the services of other HCPs' are required to provide the procedure/service. Examples include laboratory services, anaesthetist, etc.

10.11 Calculating Responsibility Values:

a. Time based consultations are to be expressed in minutes.
b. In the medium term all clinical procedures are to be cross referenced to CPT4® RVUs and a multiple of 12 applied in order to get a South African RVU.

10.12 Special Equipment:

Special equipment: All special equipment codes will each have to be costed and utilisation, purchase cost and all other expenses directly related to the equipment should be calculated to motivate for RVUs. Special equipment does not form part of the usual equipment used in rooms which forms part of the practice cost. The RVUs reflected in the Resource Based Relative Value Scale (RBRVS) and CPT4® cannot be used as is as the cost of equipment differs from that used in South Africa since most of the equipment is imported from other countries.

Equipment submission:

- Differences: Identify the major differences between the proposed equipment and other related equipment used that is already in the Doctors' Billing Manual.
- Possible savings: Indicate any savings that may be achieved if this equipment is provided instead of the one currently in use.

- Elements: Provide a detailed description that contains the following elements of the equipment:
  ~ the lifespan of the equipment
  ~ capital costs (an invoice and/or quotation must be provided)
  ~ running costs per month
  ~ proposed fee to cover purchase cost per use
  ~ total fee for equipment per use

Please note that all requests for equipment (new and revised) should be calculated in Rand amounts only (The number of units applicable to this item would be calculated after the remuneration has been finalised and it will be reflected in units in the Doctors' Billing Manual.)

For assistance with equipment submissions you may have to use actuarial and/or an accountants input in order to calculate costs, utilistion and amortisation. The details of these will be included in the Practice Cost Module.

10.13 Guidelines, interpretations and/or comments:

All disciplines must supply guidelines, interpretations and/or comments for the different codes used by their discipline.

10.14 New technology:

Identify each service/procedure that represents new technology by inserting "new technology" above the code number(s). For items that are considered as new technology, literature on the topic that supports the request for addition of a code should be provided.

11 CONCLUSION

Medical coding is a complex area requiring skilled technicians to maintain such a system. It can only be sustained if proper specialist peer review structures are in place, stakeholders are allowed to review and comment and the process is supported by actuarial and financial reviews. The process also needs to be independent of any regulatory interference.

Casper Venter

Director

19th March 2013