PHISC
Private Healthcare Information Standards Committee

PHISC Complete CPT® for South Africa (CCSA) Coding Standards and Guidelines

Proposal from the CCSA Technical Workgroup of the PHISC Clinical Coding subcommittee to Define Standards and Guidelines for the Interpretation of the CCSA / CPT® Coding Structure for Data Purposes

Date : October 2026

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Revision History

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Draft 3 version 1.00	2012/02/28	Luisa Whitelaw	Primary procedure – restructured reference sentence – "Reference the SA ICD-10 Coding Standards Document for definition of a primary diagnosis".
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Draft 3 version 1.00	2012/04/12	Crystal Wahid	1) Version "2009" removed from GPCS 0002 Modifiers "POS (Place of Service) codes in AMA CPT® 2009 book". 2) GPCS 0002 Unlisted Procedure or Service corrected to reflect GPCS 0003. 3) The following has been added: 1. GPCS 0004 General Principles of CCSA Coding for data purposes 2. Section Specific Coding Standards and Guidelines o SSCS XXXX Evaluation and Management Services o SSCS XXXX Anaesthesia o SSCS XXXX Integumentary System o SSCS XXXX Musculoskeletal System
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The PHISC Complete CPT® for South Africa (CCSA) Coding Standards have been agreed and compiled by the PHISC CCSA Technical Workgroup. Acknowledgment and thanks to the members for their contribution and efforts in making this document possible.

Introduction

This document has been compiled with the aim of documenting all coding standards and guidelines for the use of CCSA for data purposes as agreed on by the PHISC CCSA Technical Workgroup.

Coding Standards are:
1. Developed to assist the clinical coder.
2. Developed to keep a record of and track coding standards and guidelines as agreed on by PHISC.
3. To be used concurrently with the CCSA coding rules and training material.

Disclaimer:
The CCSA Coding Standards and Guidelines apply to coding for Data purposes. These Coding Standards and Guidelines do not cater for billing.

PHISC is not recommending the use of CCSA as a national procedural coding standard and therefore this document and the Workgroup will not address, discuss or make any recommendations towards the national procedural coding schema.

Note: Any persons/trainers facilitating CCSA training must conform to the copyright review requirements of the South African Medical Association (SAMA); see Appendix A for details.

Objectives
The following matrix describes the main objectives of the PHISC CCSA Technical Workgroup:

O1.	Align the interpretation and usage of CCSA as the procedural coding schema for data purposes with the training requirements defined by the Coding Qualification.	
O2.	Formulate interpretation guidelines and standards for CCSA coding to be used in the SA healthcare sector solely for data purposes. (Applicable to the relevant software used by medical schemes / scheme administrators and health establishments e.g. hospitals,)	
	O2.1	The defined interpretation guidelines and standards will be published as a document on the PHISC web site (www.phisc.org.za).
	O2.2	No standards, guidelines and / or recommendations will be defined for the usage of CCSA as the national procedural coding schema.
	O2.3	No standards, guidelines and / or recommendations will be defined for the usage of any procedural coding schemas other than CCSA.
O3.	Develop related messaging content standards (data dictionary) for data purposes. The message content standard for CCSA could be used to support the development of electronic messages such as claim authorisation requests and hospital claims and could include, but is not limited to, the specification of data element separator standards, and the inclusion or exclusion of procedural code descriptions.	
O4.	Align all interpretation guidelines and standards for CCSA usage as closely as possible to the existing AMA and CCSA rules.	

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User Guide

A standard

- a specification by which something may be tested or measured (specification – details describing something to be done)
- the required level of quality

A guideline

- a statement of principle giving general guidance

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South African Code of Ethics for Clinical Coders

Application of this Code

This Code applies to all persons doing clinical coding, irrespective of their background, experience, training or sector of work.

Coder's Ethical Principles

1) Clinical Coders shall be dedicated to providing the highest standard of clinical coding and billing services to their employers, clients and patients.

2) Clinical coders shall perform their work with honesty, attentiveness, responsibility and not exploit professional or other relationships with employers, employees, clients and patients for personal or undue commercial gain.

3) Clinical coders shall refuse to participate in or conceal any illegal, unlawful or unethical processes or procedures relating to coding or any aspect thereof.

4) Clinical coders shall participate in ongoing education to ensure that skills and knowledge meet the appropriate level of competence.

5) Clinical coders shall observe policies and legal requirements regarding patient consent, confidentiality and processing of patient-related clinical information and all personal information.

6) Clinical coders shall apply the South Africa Coding Standards and other official reporting requirements for the purposes of Clinical Coding, within what is lawful and ethical.

7) Clinical Coders should only assign and report codes that are clearly and consistently supported by practitioner documentation in the healthcare record.

8) Clinical coders shall ensure that clinical record content justifies selection of diagnosis, procedures and treatment, consulting clinicians as appropriate.

9) Clinical coders shall participate in quality improvement activities to ensure that the quality of coding supports the use of data for research, planning, evaluation and reimbursement, in the spirit of mutual respect for colleagues.

10) Clinical coders must strive to maintain and enhance the dignity, status competence and standards of coding for professional services.

11) Clinical coders shall resolve conflicts and interpretational issues in a manner that is transparent, professional and constructive, and seek guidance from professional bodies when in doubt.

12) Clinical coders shall raise matters of unprofessional coding, or coding in contravention of this code with the appropriate authorities, and not victimize any coder who exercises this right.

<u>References</u>:

Code of Ethics for Clinical Coders (Australia), the National Centre for Classification in Health (NCCH)
Coders Code of Conduct, United Kingdom (UK)
Code of Ethical Standards, American Academy of Professional Coders (AAPC)

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PHISC CCSA General Procedure Coding Standards and Guidelines (GPCS 00)

GPCS 0001 CCSA Primary Procedure[1]

Definition of a Procedure
A procedure is defined as any clinical healthcare intervention.

The primary procedure is defined as follows:
1. The main healthcare intervention primarily responsible for the patient's need for treatment or investigation at the end of the episode of healthcare.

2. The primary procedure is usually, but not necessarily, related to the primary diagnosis.
(Reference the SA ICD-10 Morbidity Coding Standards and Guidelines document for the definition of a primary diagnosis.)

3. If there are multiple procedures, the most complex procedure is usually chosen as the primary procedure.

4. If there appear to be two main procedures, then
- the one most related to the primary diagnosis should be selected as the primary procedure
- default to the first procedure listed or the one that is most resource intense if both are related to the primary diagnosis
- default to the first procedure listed or the one that is most resource intense if neither are related to the primary diagnosis

5. CCSA codes are used for data purposes and within contractual agreements between Funders and Providers of Healthcare for reimbursement. Relative Value Units (RVU's) can be used to determine the primary procedure within contractual agreements between Funders and Providers of Healthcare. Outside of contractual agreements, refer back to the primary procedure definition (GPCS 0001 Primary Procedure).

[1] There can only be **one** Primary Procedure at the end of the episode of healthcare, primarily responsible for the patient's need for treatment or investigation.

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GPCS 0002 **Modifiers**

- CCSA modifiers can be presented and stored as a five-digit code (099xx) or as a suffix to the procedural code (xxxxx-xx)
  The agreed standard is to use the five-digit code (099xx).

- Modifiers are used for information purposes in the data environment unless within a contractual arrangement.

- Sequencing of modifiers
  A modifier should always follow the code that it is modifying.
  There is no specific sequencing for more than one modifier per procedure.

  Example:
  Bilateral total hip replacement
  PPX: 27130 Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft
  SPX: 09950 Bilateral Procedure

- The following modifiers will not be used:
  Modifier 99 (if multiple modifiers are applicable to one procedure code, then they should be listed individually)
  Physical status modifiers (applies mainly to anaesthetic billing)
  Discipline code indicators
  POS (Place of Service) codes in AMA CPT® book

- Level 1 modifiers to be assigned as agreed. Reference to be made to the latest CCSA modifier spreadsheet.

Bilateral modifier
This modifier is used to report bilateral procedures that are performed at the same operative session. The use of this modifier is applicable only to services or procedures performed on identical anatomic sites, aspects or organs[2].

Add-on codes and the bilateral modifier

Add-on codes are always performed in addition to the primary service or procedure and can never be reported as a stand-alone code.
The use of modifier 09950 to indicate bilateral procedures for add on codes is no longer recommended.

The new standard is applicable from 01 January 2024:
When an add-on code is performed bilaterally, report the code twice and add the modifier 09959 (Distinct Procedural Service).

[2] American Medical Association, Principles of CPT® Coding, 6th Edition, 2010

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Example before change (prior to 01 January 2024):

Patient admitted for interphalangeal joint arthrodesis with internal fixation of second and third digits of both left and right hand.

PPX: 26860 Arthrodesis, interphalangeal joint, with or without internal fixation
SPX: 09950 Bilateral Procedure
SPX: 26861 Arthrodesis, interphalangeal joint, with or without internal fixation; each additional interphalangeal joint (List separately in addition to code for primary procedure)
SPX: 09950 Bilateral Procedure

Example after change (from 01 January 2024):

Patient admitted for interphalangeal joint arthrodesis with internal fixation of second and third digits of both left and right hand.

PPX: 26860 Arthrodesis, interphalangeal joint, with or without internal fixation
SPX: 09950 Bilateral Procedure
SPX: 26861 Arthrodesis, interphalangeal joint, with or without internal fixation; each additional interphalangeal joint (List separately in addition to code for primary procedure)
SPX: 26861 Arthrodesis, interphalangeal joint, with or without internal fixation; each additional interphalangeal joint (List separately in addition to code for primary procedure)
SPX: 09959 Distinct Procedural Service

PHISC guideline

The assignment of bilateral procedure codes may vary depending on the specific scenario and coding guidelines.

Scenario 1:
Do not append a bilateral modifier if the code description already includes the term “bilateral”.
If the procedure was only performed unilaterally and the code inherently describes a bilateral service, use modifier 09952 to indicate reduced services.

Example 1:
Procedure performed: bilateral osteotomy of the pelvis.

PPX: 27158 (Osteotomy, pelvis, bilateral (e.g. congenital malformation))

Example 2:
Procedure performed: unilateral osteotomy of the pelvis.

PPX: 27158 (Osteotomy, pelvis, bilateral (e.g. congenital malformation))
SPX: 09952 (Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the medical doctor or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier -52 (09952), signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anaesthesia, see modifiers -73 (09973) and -74 (09974))

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Scenario 2:
If the procedure was performed bilaterally and the code only describes a unilateral procedure, assign the bilateral modifier 09950.

Example:
Bilateral uniplane fixation was applied to both the left and right tibias following trauma.

PPX: 20690 Application of a uniplane (pins or wires in 1 plane), unilateral, external fixation system
SPX: 09950 Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding the modifier -50 (09950) to the appropriate 5-digit code.

Scenario 3:
The code description specifies a unilateral procedure and includes guidance to append modifier 09950 for bilateral cases.
In such cases, the procedure is effectively coded as **unilateral/bilateral**, depending on whether modifier 09950 is added.

PPX: 27215 Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral, for pelvic bone fracture patterns that do not disrupt the pelvic ring, includes internal fixation, when performed
(To report bilateral procedure, report 27215 with modifier 09950)

Discontinued procedure or surgery not performed
Ensure that the ICD-10 diagnosis code(s) assigned as per DSN 2136 Surgery not performed align with the CCSA code(s) and modifier(s) assigned.

How should we apply the modifiers in addition to the add-on codes for "thoracoscopic wedge resection of nodules in both lungs"?

Example:
Thorascopic wedge resection of nodules in both lungs. 1 nodule was resected in the right lung and 2 nodules were resected in the left lung. Note that 32667 applies to one lung only.

The code assignment and use of modifiers in this example was agreed to as follows:
PPX: 32666 Thoracoscopy, surgical; with therapeutic wedge resection (e.g. mass, nodule), initial unilateral
SPX: 09950 Bilateral Procedure
SPX: 32667 Thoracoscopy, surgical; with therapeutic wedge resection (e.g. mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)

- Modifier 099LT will not be assigned as not all organizations can accommodate laterality.

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Which CCSA codes should be assigned for redo/revision procedures?

Assign a code for the re-do or revision if a code exists.

Example:
33510 Coronary artery bypass, vein only; single coronary venous graft
33530 Re-operation, coronary artery bypass procedure or valve procedure, more than 1 month after original operation (List separately in addition to code for primary procedure)

- Assign 33530 in addition to the code for the coronary artery bypass procedure or valve procedure.

If a re-do or revision code does not exist, assign an appropriate CCSA modifier in addition to the procedure.

Example:
43280 Laparoscopy, surgical, oesophagogastric fundoplasty (e.g. Nissen, Toupet procedures)
09976 Repeat Procedure by Same Medical Practitioner or Other Qualified Health Care Professional

Or

43280 Laparoscopy, surgical, oesophagogastric fundoplasty (e.g. Nissen, Toupet procedures)
09977 Repeat Procedure by Another Medical Practitioner or Other Qualified Health Care Professional

Guidelines for the assignment and use of Modifier 09959

When to use Modifier 09959
Assign modifier 09959 in the following circumstances:
1. Bilateral performance of add-on procedures
   - When an add-on procedure is performed bilaterally and the code description does not otherwise account for bilateral performance.
     📖 See notes and examples below bilateral modifier
2. Procedures not normally performed together
   - When two procedures are ordinarily considered mutually exclusive or are not normally reported together, but documentation supports that both services were independently performed.
     📖 See example 4 below **GPCS** 0009 **Coding of a Laparoscopic procedure which converts to an Open procedure**
3. When CCSA coding rules prohibit code combinations
   - When the CCSA coding rules indicate that two procedures should not normally be reported together but the circumstances of the case support separate reporting. Assign modifier 09959 where documentation demonstrates that the procedures were distinct and separately reportable.
4. Repeated performance of the same procedure on the same organ or structure
   - When the same procedure is performed multiple times during the same session and the code descriptor does not specify, each lesion, each additional procedure, or a specific number etc. For example, multiple lesions requiring separate destruction or biopsy where the code descriptor does not define the number of lesions treated.

When not use Modifier 09959
Modifier 09959 should not be assigned in the following circumstances:
1. A more specific modifier is available
   - If another modifier more accurately describes the circumstance, assign the more specific modifier instead of 09959.
2. Same procedure performed during a different session

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- When a procedure is repeated during a separate operative session, use the appropriate repeat-session modifier instead, for example, 09976, 09977, 09978 or 09979.

3. Same procedure performed on different dates
   - The service dates adequately distinguish the procedures.
   - Modifier 09959 should not be assigned when repeat services are distinguished by separate service dates.
4. Distinct anatomical sites already represented by different CCSA codes
   - Do not assign modifier 09959 when procedures performed on different organs, anatomical sites, separate lesions, or separate injuries are already adequately represented by distinct CCSA procedure codes.
5. When the code descriptor includes "each" or "each additional"
   - Follow the coding instructions inherent in the code descriptor. For example, arteries, spinal levels, joints, digits, additional vessels, additional lesions etc.
   - Report the appropriate primary and add-on codes rather than using modifier 09959.
6. Integumentary procedures
   - For procedures such as lesion destruction, excision, and debridement, follow the specific CCSA coding instructions for lesion count, size, or area treated.
   - Do not use modifier 09959 to indicate multiple lesions when specific coding instructions already exist.
7. Repeated unilateral add-on procedures
   - Do not assign modifier 09959 when a unilateral add-on procedure is repeated
8. Distinctly different CCSA procedure codes assigned
   - Do not assign modifier 09959 when two separate and distinct CCSA procedure codes are assigned.
     Note: This guideline overrides any notes preceding a section, subsection, or individual procedure code in CPT®/CCSA.

Modifier 099TC (Technical Component)

Guideline for the use of Modifier 099TC (Technical Component)

In South Africa, modifier 099TC has been adopted to indicate a laparoscopic approach in specific scenarios. While intended to denote the technical component of a procedure, it may also be used to reflect the laparoscopic approach where applicable.

General rules for modifier 099TC

- Do not assign modifier 099TC if the laparoscopic approach is already included in the procedure code description.
- Modifier 099TC cannot be used for procedures where a laparoscopic code does not exist unless agreed to by the PHISC Technical Working Group.

Approved applications of modifier 099TC

- Modifier 099TC must be assigned in addition to the hernia repair codes (49591 – 49596 and 49613 – 49622) and 49623 to indicate a laparoscopic approach.
- The use of modifier 099TC has been approved for the following procedures, provided they are performed laparoscopically.
  - 43285 (Removal of oesophageal sphincter augmentation device)
  - 43845 (Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch))
  - 51920 (Closure of vesico-uterine fistula;)
  - 51925 (Closure of vesico-uterine fistula; with hysterectomy)
  - 58350 (Chromotubation of oviduct, including materials)

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Note:
The use of modifier 099TC is currently limited to the above procedure codes.

For CPT®/CCSA procedure codes where the term "laparoscopic" is not explicitly stated in the code description, but where reference resources such as the Procedure Desk Reference or Coders' Desk Reference for Procedures indicate that this procedure may be performed laparoscopically, then the modifier 099TC (Technical Component) may be assigned in addition to the CPT®/CCSA surgical code(s) to indicate the laparoscopic approach, provided that this was indeed the method used. However, the 099TC modifier must not be added if the reference sources do not mention a laparoscopic approach, or if the CPT®/CCSA long description already specifies that the procedure may be done laparoscopically.

The PHISC CCSA Technical Working Group will define and maintain the list of codes where modifier 099TC may be applied.

Disclaimer: The *PHISC Complete CPT® for South Africa (CCSA) Coding Standards and Guidelines* document is updated and published annually. Any new additions to the defined list of codes or standards are subject to review and approval by the PHISC Clinical Coding Subcommittee. Please note that approved changes will only be incorporated into the next scheduled annual update and interim versions will not be published to reflect new codes or standards.

GPCS 0003 **Unlisted Procedure or Service**

It is recognised that there may be services or procedures performed by medical doctors or other qualified health care professionals that are not found in CPT®. A number of specific code numbers have therefore been designated for reporting unlisted procedures. *Official acceptance by the relevant speciality group of such "new" procedures is required before the appropriate code for an unlisted procedure can be used. When an unlisted procedure number is used, the service or procedure should be described. Each of these unlisted procedural code numbers (with the appropriate accompanying topical entry) relates to a specific section of the book and is presented in the Guidelines of that section*.[3]

Codes have been designated to report services or procedures that are not found in the CPT® book. These codes usually end in the number 99. When an unlisted procedure code is used, a manual review by the payer is necessary.
Documentation, such as operative notes and a cover letter, should be submitted with the claim.[4]

- **When an unlisted code is assigned, the description of the healthcare intervention must be supplied to the healthcare funder.**
- **When there are two possible unlisted codes for one procedure, where one indicates the approach and the other indicates the anatomical site, then the approach should take precedence.**
  The ICD-10 diagnosis code will reflect the specific site.
- **Assign the bilateral modifier for bilateral unlisted procedures that are performed at the same operative session**
- **The ICD-10 code assigned should be considered as this will give an indication of the anatomical site.**

[3] Complete CPT® for South Africa (CCSA) 2018 Edition, Volume I
[4] 2012 Coders' Desk Reference for Procedures

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- ❖ **The NAPPI code should also be considered as this will give an indication of the specific ethical drug used.**

Example 1:
Laparoscopic resection of Meckel's diverticulum

Use **44238 Unlisted laparoscopy procedure, intestine (except rectum)** instead of **44899 Unlisted procedure, Meckel's diverticulum and the mesentery**.

Example 2:
Bilateral laparoscopic ureterolysis

PPX: 50949 Unlisted laparoscopy procedure, ureter
SPX: 09950 Bilateral Procedure

GPCS 0004 **General Principles of CCSA Coding for data purposes**

1. Refer to existing guidelines within the CCSA book (Volume 1)
    - Unbundling of Codes
    - Add-on Codes
    - Separate Procedure
    - Surgical Destruction
    - Special Report

2. Obtain detailed information from the medical record in order to assign an accurate code.

- ❖ Documentation in medical records is the basis for communication between health professionals. It informs of the care provided, the treatment and care planned and the outcome of that care as a continuous and contemporaneous record. Documentation enables health professionals and other care providers to use accurate, consistent data and care goals to facilitate continuity of care. Clear, complete, accurate and factual documentation provides a reliable permanent record of patient care and is an accurate record of that history of the patient's health care.[5]

3. The term Physician will be replaced by Medical Doctor.

4. Healthcare Providers and Funders can utilize an agreed set of CCSA codes within a contractual agreement.

5. These standards and guidelines are not prescriptive on the place of service.

6. Make reference to the coding rules, guidelines and tips available in Volume I

7. When assigning codes for multiple procedures e.g. multiple lesions, ventilation days etc. assign codes as per the CCSA rules. Capturing of this information is at the individual healthcare provider or healthcare funder discretion based on business requirements and system capability.

8. Default to the smallest size, least number, lowest complexity etc. if the information is insufficient.

[5] Guidelines for Medical Record and Clinical Documentation, WHO-SEARO Coding Workshop, September 2007

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GPCS 0005 **Updating of the PHISC CCSA Coding Standards and Guidelines Document**

The PHISC CCSA Coding Standards and Guidelines document will be updated annually unless an urgent change is required. Any requests for updates, corrections and amendments can be submitted to the PHISC Clinical Coding sub-committee.

A summary of changes will be compiled and included in the SA coding standards document after each update. A three-month period will be allowed for the implementation of any operational changes and a six-month period for any system-related changes. A standard which is no longer valid will be removed. The standard number will not be re-used.

The latest version of the PHISC CCSA Coding Standards and Guidelines document will be available on the PHISC website (www.phisc.net).

The latest version must be referenced and used together with the latest CCSA volumes or electronic version when coding and / or facilitating a coding course in the medical and or health insurance environment of SA.

GPCS 0006 **Paper and Electronic Claims containing CCSA Codes**

CCSA code descriptions must not be displayed in order to maintain a patient's privacy and confidentiality.[6]

GPCS 0007 **Reference to CCSA and CPT®**

CCSA and CPT® must be referenced correctly in any documentation or communication, as per the relevant SAMA or AMA license agreement held by each user.

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[6] Reference: Minutes of the PHISC Clinical Coding Subcommittee Meeting (Thursday, 21 May 2015)

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GPCS 0008 **CCSA Code to be assigned when a procedure approach is not described as "open" or "laparoscopic"**

The environment within which coding is done should not allow for the use of a default code. The details of the intervention need to be investigated to establish if the approach was open or laparoscopic in order for the appropriate code to be assigned. This ties in with the principles in our Coders' Code of Ethics.

GPCS 0009 **Coding of a Laparoscopic procedure which converts to an Open procedure**

The open procedure must be assigned followed by the laparoscopic procedure and a modifier must be assigned to indicate that the laparoscopic procedure was discontinued.

Sequencing of modifiers

- A modifier should always follow the code that it is modifying.
- There is no specific sequencing for more than one modifier per procedure.

Example 1:
A patient is booked for a laparoscopic cholecystectomy. The doctor commences the procedure, including dissection. For some reason, he is not able to continue the procedure and complete the procedure laparoscopically. An open cholecystectomy procedure is then performed.

Assign as follows:
PPX: 47600 Cholecystectomy
SPX: 47562 Laparoscopy, surgical; cholecystectomy
SPX: 09953 Discontinued procedure

Example 2:
Attempted endoscopic carpal tunnel release proceeded to an open procedure.
PPX: 64721 Neuroplasty and/or transposition; median nerve at carpal tunnel
SPX: 29848 Endoscopy, wrist, surgical, with release of transverse carpal ligament
SPX: 09953 Discontinued Procedure

- Please refer to **SSCS** 2000 **Musculoskeletal System** (20005 – 29999) for an open procedure that follows a diagnostic endoscopy on the same site.

One should take into account if the procedure was performed on the same side (i.e. right or left)

Note:

- This standard applies when coding discontinued endoscopic and thoracoscopic procedures that convert to open procedures.
- The coding note stating "Do not report 58570-58573 in conjunction with 49320, 57000, 57180, 57410, 58140-58146, 58150, 58545, 58546, 58561, 58661, 58670, 58671" does not apply within the CCSA coding for data environment, as there is no specific code available to indicate that a laparoscopic surgical procedure was converted to an open procedure.

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09953 Discontinued Procedure: Under certain circumstances, the medical doctor or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the wellbeing of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding the modifier -53 (09953) to the code reported by the individual for the discontinued procedure. **Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anaesthesia induction and/or surgical preparation in the operating suite.** For outpatient hospital/ambulatory surgery centre (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the wellbeing of the patient prior to or after administration of anaesthesia, see modifiers -73 (09973) and -74 (09974).

Modifier 09953 is used to denote a surgical or diagnostic procedure terminated by the physician because of concerns about the procedure's impact on the patient's wellbeing. Add modifier 09953 to the code for the discontinued procedure. This code can only be used if the procedure was discontinued after anaesthesia was administered and/or the patient was prepped in the operating suite.

Example 3:
The planned procedure was a total thyroidectomy for malignancy with radical neck dissection. The surgeon attempted the procedure. The planned procedure was terminated due to the extensive, unresectable disseminated invasive tumour.

PPX: 60254 Thyroidectomy, total or subtotal for malignancy; with radical neck dissection
SPX: 09953 Discontinued Procedure

Example 4:
Following a diagnostic laparoscopy, an open cholecystectomy was performed. (The doctor performed the full diagnostic procedure, and did not "discontinue" the procedure).

PPX: 47600 Cholecystectomy
SPX: 49320 Laparoscopy, abdomen, peritoneum and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing.
PPX: 09959 Distinct Procedural Service

GPCS 0010 **Global Period**

Refer to the CCSA global period description. Do not overlap with the global periods in other coding schemas such as the Reference Price List.

GPCS 0011 **Gender edits for specific procedures/scenarios**

Existing gender flags will not be changed to accommodate certain procedures that conflict with the patient's gender. Each organization must have the ability to override the gender edits for specific procedures/scenarios.

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GPCS 0012 **Code to indicate robotic assistance**

Assign the HCPCS code S2900 (Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure)) in addition to the code for the procedure performed to indicate a robotic approach.

Example 1:
Patient had a laparoscopic simple subtotal prostatectomy.

PPX: 55867 (Laparoscopy, surgical prostatectomy, simple subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy), includes robotic assistance, when performed

- The modifier 099TC (Technical Component) should not be assigned in addition to 55867 to indicate a laparoscopic approach as the code description caters for the laparoscopic approach.

Example 2:
Patient had a laparoscopic radical prostatectomy and bilateral pelvic lymphadenectomy with robotic assistance.

PPX: 55869 (Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes)
SPX: S2900 (Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure))

Example 3:
Patient went for a laparoscopic radical nephrectomy with robotic assistance.

PPX: 50545 (Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy))
SPX: S2900 (Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure))

Computer-Assisted Navigation (CAN)

Assign the appropriate add-on codes for computer-assisted navigation (CAN) in addition to the primary musculoskeletal or orthopedic procedure codes when CAN is used intraoperatively.

- 20985 (Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure))
- 0054T (Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure))
- 0055T (Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure))

Do not assign CAN add-on codes in conjunction with S2900, as the use of computer navigation is already considered included in the robotic-assisted procedure represented by S2900.

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PHISC CCSA Section Specific Coding Standards and Guidelines

SSCS 9900 **Evaluation and Management Services** (99201 – 99499)

Evaluation and management services codes are currently not utilised for data purposes and thus no standards are recommended for this section.

SSCS 0000 **Anaesthesia** (00100 – 01999)

Anaesthetic codes are currently not utilised for data purposes and thus no other standards or guidelines are recommended for this section.

SSCS 1000 **General** (10021 – 10022)

There are no specific South African data standards for this section.

SSCS 1000 **Integumentary System** (10040 – 19499)

In order to assign an appropriate code specific information is required e.g. size, depth, diameter etc.

a) Obtain the information from the medical doctor.
b) If this information is not available:
   - Default to the smallest size, least number, lowest complexity etc.
   - Default to benign if there is no indication of the type of tissue / morphology and there is no indication given by the assigned ICD-10 code.

SSCS 2000 **Musculoskeletal System** (20005 – 29999)

When a diagnostic endoscopy/arthroscopy is followed by an open procedure on the same site, assign a code for the open surgical procedure as the primary procedure (PPX) and a code for the diagnostic endoscopy/arthroscopy as the secondary procedure (SPX).

Example:
Patient had a diagnostic arthroscopy of the knee which was followed by an arthrotomy with a meniscus repair.
PPX: 27403 Arthrotomy with meniscus repair, knee
SPX: 29870 Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)

PHISC guideline:
Code for a torn pectoralis major muscle repair
Assign 24341 (Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)) instead of an unlisted code for a torn pectoralis major muscle repair.

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Revision arthroplasty
For arthroplasty procedures where no specific revision code exists, refer to the guideline "which CCSA codes should be assigned for redo/revision procedures" for coding instructions.

Coding of a sacral kyphoplasty

There is no permanent CPT®/CCSA Category I code for sacral kyphoplasty (more accurately termed sacroplasty with cavity creation). Sacral kyphoplasty should be reported using the appropriate Category III CPT®/CCSA codes for sacral augmentation.

- 0200T (Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including balloon or mechanical device when used, imaging guidance, and bone biopsy when performed)
- 0201T (Percutaneous sacral augmentation (sacroplasty), bilateral injection(s), including balloon or mechanical device when used, imaging guidance, and bone biopsy when performed)

These codes specifically describe sacral augmentation procedures, irrespective of the technique used to prepare the cavity. Therefore, procedures performed using a balloon (kyphoplasty-type technique) or an alternative mechanical cavity-creation device are reported using the same Category III sacroplasty codes.

SSCS 3000 **Respiratory System** (30000 – 32999)

PHISC guideline:
Coding of a functional endoscopic sinus surgery (FESS) procedure with the use of a Stealth Station

FESS *without* any mention of intradural access and/or surgery, or involvement of a neurosurgeon – use applicable code for FESS and 61782 (Stereotactic computer-assisted (navigational) procedure; cranial, extradural (List separately in addition to code for primary procedure)).

FESS *with* mention of intradural access and/or surgery and involvement of neurosurgeon – use applicable code for FESS and 61781 (Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure)).

Example 1:
FESS performed for repair of cerebrospinal fluid leak in the ethmoid region, Stealth station used during the procedure.

PPX: 31290 Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; ethmoid region
SPX: 61782 Stereotactic computer-assisted (navigational) procedure; cranial, extradural (List separately in addition to code for primary procedure)

Example 2:
Stealth assisted nasal endoscopy for orbital decompression of inferior wall performed.

PPX: 31292 Nasal/sinus endoscopy, surgical; with orbital decompression; medial or inferior wall
SPX: 61781 Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure)

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PHISC guideline:
32674 (Thoracoscopy, surgical; with mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)) can be assigned together with codes for open approaches.

Report 32674 in conjunction with 21601, 31760, 31766, 31786, 32096 - 32200, 32220 - 32320, 32440 - 32491, 32503 - 32505, 32601 - 32663, 32666, 32669 - 32673, 32815, 33025, 33030, 33050 - 33130, 39200 - 39220, 39560, 39561, 43101, 43112, 43117, 43118, 43122, 43123, 43287, 43288, 43351, 60270, 60505.

Example:
Patient had a partial oesophagectomy with oesophagogastrostomy via an abdominal approach and a thoracoscopic mediastinal lymphadenectomy.

PPX: 43122 (Partial oesophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with oesophagogastrostomy, with or without pyloroplasty)
SPX: 32674 (Thoracoscopy, surgical; with mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)) can be assigned together with open and thoracoscopic procedure codes.

SSCS 3300 **Cardiovascular System** (33016 – 37799)

Endovascular revascularisation (Open or Percutaneous, Transcatheter)

📖 refer to notes in CPT®/CCSA books when coding from this section.

“When the same territory(ies) of both legs are treated in the same session, modifiers may be required to describe the interventions. Use **modifier –59 (09959)** to denote that different legs are being treated, even if the mode of therapy is different”.

Example 1:
Left leg: popliteal artery occlusion was opened with a balloon catheter, and a stent was inserted and the superficial femoral artery was dilated with a drug eluting balloon.
Right leg: popliteal artery was repaired with a stent.

PPX: 37275 Revascularisation, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterising the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel
SPX: 37275 Revascularisation, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterising the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel
SPX: 09959 Distinct Procedural Service

- Use the **bilateral modifier (09950)** if the intervention is exactly the same on both limbs.

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🕮 **GPCS** 0002 **Modifiers**

09959 Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier -59 (09959) is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. **Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.** However, when another already established modifier is appropriate it should be used rather than modifier -59 (09959). Only if no more descriptive modifier is available, and the use of modifier -59 (09959) best explains the circumstances, should modifier -59 (09959) be used. Note: Modifier -59 (09959) should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier -25 (09925).

See example 4, **GPCS** 0009 **Coding of a Laparoscopic procedure which converts to an Open procedure**

SSCS 3800 **Haemic and Lymphatic Systems** (38100 – 38999)

Guideline for cord blood stem cell harvesting
CCSA codes 38205 Blood-derived haematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic and 38206 Blood-derived haematopoietic progenitor cell harvesting for transplantation, per collection; autologous can be assigned for cord blood stem cell harvesting.

For cryopreservation and storage, assign 38207 Transplant preparation of haematopoietic progenitor cells; cryopreservation and storage.
This code will be applicable in the appropriate setting.

SSCS 3900 **Mediastinum and Diaphragm** (39000 – 39599)

There are no specific South African data standards for this section.

SSCS 4000 **Digestive System** (40490 – 49999)

CPT® / CCSA code 43285
CPT® / CCSA code 43285 Removal of oesophageal sphincter augmentation device will be considered to be laparoscopic although not stated as such in the description. This code is listed below section 4.10.8.5 Laparoscopy[7].

[7] Complete CPT® for South Africa (CCSA) 2018 Edition, Volume I

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CPT® / CCSA code 46700 and 46705
CPT® / CCSA Codes 46700 Anoplasty, plastic operation for stricture; adult and 46705 Anoplasty, plastic operation for stricture; infant

- Do not apply an adult age edit to 46700 as there is no code for an “anoplasty, plastic operation for stricture” for a child (not considered an infant).

Coding of faecal transplants
Assign 44705 Preparation of faecal microbiota for instillation, including assessment of donor specimen for the preparation and the unlisted code 44799 for the instillation.

Coding of dental and maxilla-facial procedures

CPT®/CCSA codes do not cater for dentistry. The addition of the South African Dental Association (SADA) codes caters for the detail required. Therefore, CPT® / CCSA code 41899 must be assigned together with the SADA codes where available. CPT® / CCSA code(s) for maxilla-facial surgery to be assigned where appropriate.

Example 1:
Patient for surgical removal of impacted teeth x3 (SADA codes provided: 8941, 8943 and 8945)

PPX: 41899 Unlisted procedure, dentoalveolar structures
Capture SADA codes:
8941 Surgical removal of impacted tooth - first tooth
8943 Surgical removal of impacted tooth - second tooth
8945 Surgical removal of impacted tooth - third and subsequent teeth

Example 2:
Patient for re-implantation of tooth x1 (SADA code provided: 8517)

PPX: 41899 Unlisted procedure, dentoalveolar structures
Capture SADA code:
8517 Reimplantation of avulsed tooth (include stabilisation)

Example 3:
Patient for arthrocentesis of TM joint (SADA code provided: 9076)
SADA code 9076 (TM joint procs: Arthrocentesis TMJ/ Arthrosintese TMG)

PPX: 20605 Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (e.g. temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance

Example 4:
Patient for excision of malignant tumour of zygoma (SADA code provided: 8973)
SADA code 8973 (NEOPLASMS: Surgical treatment of tumours of the jaws)

PPX: 21034 Excision of malignant tumour of maxilla or zygoma

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PHISC coding standards and guidelines for hernia codes 49591 – 49623 in addition to the notes provided in the CPT 2024® and CCSA2024 codebooks.

Coding anterior abdominal hernias repairs
Codes 49591 – 49618 describe repair of an anterior abdominal hernia(s) (i.e. epigastric, incisional, ventral, umbilical and spigelian by any approach (i.e. open, laparoscopic, robotic).

Codes 49591 – 49618 are reported only once, based on the total defect size for one or more anterior abdominal hernia(s), measured as the maximal craniocaudal or transverse distance between the outer margins of all defects repaired.

When both reducible and incarcerated or strangulated anterior abdominal hernias are repaired at the same operative session, all hernias are reported as incarcerated or strangulated.

Inguinal, femoral, lumbar, omphalocele, and/or parastomal hernia repair may be separately reported when performed at the same operative session as anterior abdominal hernia repair by appending modifier 09959, as appropriate.

Implantation of mesh or other prosthesis, when performed, is included in 49591- 49622 and may not be separately reported. For total or near total removal of non-infected mesh when performed, use 49623 in conjunction with 49591 – 49622. For removal of infected mesh, use 11008[8].

Reference: CPT 2024® and CCSA2024 codebooks

PHISC Coding Standard

To code the different approaches, assign the:

- HCPCS code S2900 (Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure)) in addition to the hernia repair code (49591 – 49618) **to indicate a robotic approach**.

  Example:
  PPX: 49591 (Repair of anterior abdominal hernia(s) (i.e. epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e. open, laparoscopic, **robotic**), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible)
  SPX: S2900 (Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure))

- Modifier 099TC (Technical Component) in addition to the hernia repair code (49591 – 49618) **to indicate a laparoscopic approach**.

  Example:
  PPX: 49591 (Repair of anterior abdominal hernia(s) (i.e. epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e. open, **laparoscopic**, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible)
  SPX: 099TC (Technical Component)

  The use of modifier 099TC (Technical Component) is currently limited to the hernia codes 49591 – 49623.

[8] Reference: CPT 2024® and CCSA2024 codebooks

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- Assign a code (49591 – 49618) for the hernia repair without an additional code **to indicate an open approach**.

  Example:
  PPX: 49591 (Repair of anterior abdominal hernia(s) (i.e. epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e. **open**, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible)

This coding standard applies to the following codes:

- 49621 (Repair of para-stomal hernia, any approach (i.e. open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; reducible)
- 49622 (Repair of para-stomal hernia, any approach (i.e. open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; incarcerated or strangulated)
- 49623 (Removal of total or near total non-infected mesh or other prosthesis at the time of initial or recurrent anterior abdominal hernia repair or para-stomal hernia repair, any approach (i.e. open, laparoscopic, robotic) (List separately in addition to code for primary procedure))

Coding of a laparoscopic hernia repair which converts to an open hernia repair
The open procedure must be assigned followed by the laparoscopic procedure and a modifier must be assigned to indicate that the laparoscopic procedure was discontinued.

Example:
Patient booked for a laparoscopic umbilical hernia repair. An open umbilical hernia repair was performed following an attempted laparoscopic approach.

PPX: 49591 (Repair of anterior abdominal hernia(s) (i.e. epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e. **open**, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible)
SPX: 49591 (Repair of anterior abdominal hernia(s) (i.e. epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e. open, **laparoscopic**, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible)
SPX: 099TC (Technical Component)
SPX: 09953 (Discontinued procedure)

Coding the repair of 2 abdominal hernias during the same theatre event

- Codes 49591 – 49618 describe repair of an anterior abdominal hernia(s) (i.e. epigastric, incisional, ventral, umbilical and spigelian by any approach (i.e. open, laparoscopic, robotic).
- Codes 49591 – 49618 are reported only once, based on the total defect size for one or more anterior abdominal hernia(s), measured as the maximal craniocaudal or transverse distance between the outer margins of all defects repaired.
- Default to the lowest size if the information is not available.

Example 1:
Patient for an incisional and epigastric hernia repair.

PDX: K43.2 (Incisional hernia without obstruction or gangrene)
SDX: K43.9 (Other and unspecified ventral hernia without obstruction or gangrene)

PPX: Assign a code from 49591 – 49618 for an initial and reducible hernia based on the total defect size of both hernias.

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- When both reducible and incarcerated or strangulated anterior abdominal hernias are repaired at the same operative session, all hernias are reported as incarcerated or strangulated.

Example 2:
Patient for a repair of an incisional hernia causing obstruction and an epigastric hernia repair.

PDX: K43.0 (Incisional hernia with obstruction, without gangrene)
SDX: K43.9 (Other and unspecified ventral hernia without obstruction or gangrene)

PPX: Assign a code from 49591 – 49618 for an initial and strangulated hernia based on the total defect size of both hernias.

- Inguinal, femoral, lumbar, omphalocele, and/or parastomal hernia repair may be separately reported when performed at the same operative session as anterior abdominal hernia repair by appending modifier 09959, as appropriate.

Example 1:
Patient for an inguinal and an incisional hernia repair. Both procedures performed laparoscopically.

PDX: K40.9 (Unilateral or unspecified inguinal hernia, without obstruction or gangrene)
SDX: K43.2 (Incisional hernia without obstruction or gangrene)

PPX: 49650 (Laparoscopy, surgical; repair initial inguinal hernia)
SPX: 49591 (Repair of anterior abdominal hernia(s) (i.e. epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e. open, **laparoscopic**, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible)
SPX: 099TC (Technical Component)

Assigning other modifiers such as 09959 (Distinct Procedural Service) is not necessary in the above example.

Coding initial and recurrent hernia repairs at the same operative session
Assign a code for the recurrent hernia repair based on the relative value units (RVUs).

Example 1:
Patient for a recurrent epigastric hernia repair and an initial incisional hernia repair. Both procedures performed laparoscopically. Total length of defect documented as 6 cm.

PDX: K43.9 (Other and unspecified ventral hernia without obstruction or gangrene)
SDX: K43.2 (Incisional hernia without obstruction or gangrene)

PPX: 49615 (Repair of anterior abdominal hernia(s) (i.e. epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e. open, **laparoscopic**, robotic), **recurrent**, including implantation of mesh or other prosthesis when performed, total length of defect(s); **3 cm to 10 cm**, reducible)
SPX: 099TC (Technical Component)

Example 2:
Patient for a recurrent epigastric hernia repair and an initial incarcerated incisional hernia repair. Both procedures are performed laparoscopically. Total length of defect documented as 6 cm.

PDX: K43.0 (Incisional hernia with obstruction, without gangrene)
SDX: K43.9 (Other and unspecified ventral hernia without obstruction or gangrene)

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PPX: 49616 (Repair of anterior abdominal hernia(s) (i.e. epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e. open, **laparoscopic**, robotic), **recurrent**, including implantation of mesh or other prosthesis when performed, total length of defect(s); **3 cm to 10 cm, incarcerated or strangulated**)
SPX: 099TC (Technical Component)

The medical practitioner should record the total length of defect or refer to the CPT 2024® and CCSA2024 codebooks when determining the total length of defect.

Note:
When a hernia procedure is performed laparoscopically with additional robotic guidance (e.g. Da Vinci), only S2900 or 099TC should be assigned, and not both.

Coding of an Endoscopic Ultrasound (EUS)

Assign the appropriate CPT®/CCSA code with the descriptor “with endoscopic ultrasound” or “with transendoscopic ultrasound-guided” from the code range 43231-45392 when an Endoscopic Ultrasound (EUS) is performed. These codes should be assigned in preference to an unlisted procedure code. The EUS code includes the use of an echoendoscope or ultrasound probe as part of the procedure.

Codes 43232, 43238, and 43242 include the fine-needle aspiration/biopsy (FNA/FNB) component and should not be reported separately.

Example:
Refer to the descriptor for code 43237 in the *2026 Optum Coders' Desk Reference for Procedures*, which describes an oesophagogastroduodenoscopy (EGD) performed with endoscopic ultrasound examination.

43237 (Oesophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the oesophagus, stomach or duodenum, and adjacent structures).

From the 2026 Optum Coders' Desk Reference for Procedures:
The physician performs an esophagogastroduodenoscopy (EGD) with a concomitant ultrasound examination for diagnostic purposes. The patient is prepped for an upper gastrointestinal exam and the scope is advanced through the mouth into the stomach and duodenum or jejunum. An examination is carried out to determine if any bleeding, tumours, erosions, ulcers, or other abnormalities are present. Report 43237 when the endoscope exam is followed by **insertion of an echoendoscope** for an ultrasound exam limited to the esophagus, stomach, duodenum, and adjacent structures. Report 43238 when the **echoendoscope** is inserted following the EGD examination and an ultrasound and transmural fine needle aspiration biopsy is performed.
Refer to the 2026 Optum Coders’ Desk Reference for Procedures for the complete description.

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Guideline for Coding Lysis of Liver Adhesions

The indexing for adhesions involving the liver is incorrect in both the CPT® and CCSA coding manuals.
Adhesions
- Liver
- - Lysis 58660

Code 58660 (Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)) is classified within the Female Genital System section (code range 56405-58999) and should not be assigned for lysis of liver adhesions.
Code 44180 (Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion) (separate procedure)) should be assigned instead of 58660.

When considering the assignment of a code for lysis of adhesions, do not assign a code based solely on the documentation of adhesions in the operative report. Adhesions may be incidental findings, and the division or release may be an integral component of the primary procedure being performed.

The indexing of Gastroenterostomy is incorrect in both the CPT® and CCSA 2026 coding manuals.

Roux-En-Y Procedure
Anastomosis
Laparoscopic Gastroenterostomy **43644** ~~43846~~

Gastroenterostomy
for Obesity
Laparoscopic **43644** ~~43645~~

SSCS 5000 **Urinary System** (50010 – 53899)

Laparoscopic ureterolysis
It would be appropriate to assign the unlisted laparoscopic CCSA code 50949 Unlisted laparoscopy procedure, ureter if separately identifiable and performed with another procedure.

Guideline for 52214
CPT® / CCSA Code 52214 Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands

- This code is not gender specific, it can be assigned for both male and female patients.

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Guideline for 51500 and when to add an additional code for the umbilical hernia repair
51500 (Excision of urachal cyst or sinus, with or without umbilical hernia repair)

A coder should establish whether a simple or complex hernia repair was performed by reviewing the operative report and/or obtaining the necessary information from the medical practitioner.

- A simple umbilical hernia repair, for example, 49591 (Repair of anterior abdominal hernia(s) (i.e. epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e. open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible) could be bundled into 51500.
- It would be appropriate to assign an additional code for a complex umbilical hernia repair. A complex hernia could be a hernia that is incarcerated or strangulated, a hernia with gangrene or one following previous procedures and/or complications or one that is difficult to repair.

SSCS 5400 **Male Genital System** (54000 – 55899)

55875 Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy includes the insertion of the radioactive seeds.

The following codes can be assigned in addition to 55875 (Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy) to provide information on the complexity.

- 77770 Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel
- 77771 Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 2-12 channels
- 77772 Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; over 12 channels
- 77778 Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed

For ultrasonic guidance for interstitial radioelement application, assign 76965 (Ultrasonic guidance for interstitial radioelement application).

SSCS 5500 **Reproductive System Procedures** (55920)

There are no specific South African data standards for this section

SSCS 5500 **Intersex Surgery** (55970 – 55980)

There are no specific South African data standards for this section

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SSCS 5600 **Female Genital System** (56405 – 58999)

Laparoscopic ovarian drilling (ovarian diathermy) for Polycystic Ovary Syndrome (PCOS)

The CCSA code 58662 Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method should be used for laparoscopic ovarian drilling for Polycystic Ovary Syndrome (PCOS).

- **This code should not be used for laparoscopic ovarian drilling for other reasons.**

Labial reduction
15839 Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area is the appropriate code to use for labial reduction.
56620 Vulvectomy simple; partial should not be used for labial reduction.

Laparoscopic excision/fulguration of ovarian endometriosis
58662 Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method can be assigned for the laparoscopic excision/fulguration of ovarian endometriosis.

As per the AAPC Procedure Desk Reference 2016, “Typically, the provider removes endometriosis during this procedure or lesions on the ovaries or fallopian tubes such as cysts”[9].

SSCS 5900 **Maternity Care and Delivery** (59000 – 59899)

Guideline
The following codes should be treated in the same way as the evaluation and management services codes and should not be utilized for data purposes. No standards are recommended for these codes.

- 59425 Ante-partum care only; 4-6 visits
- 59426 Ante-partum care only; 7 or more visits
- 59430 Post-partum care only (separate procedure)

Fetal Procedures / Surgery in Utero
Assign the unlisted CCSA code where there is no specific procedure code as per GPCS 0003 Unlisted Procedure or Service.

Fetoscopic laser therapy for treatment of twin-to-twin transfusion syndrome
Assign 59072 Foetal umbilical cord occlusion, including ultrasound guidance for fetoscopic laser therapy for the treatment of twin-to-twin transfusion syndrome.

[9] AAPC Procedure Desk Reference 2016

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Guideline for application of a B-Lynch suture
Assign modifier 09922 Increased Procedural Services in addition to the code for the caesarean section for the application of a B-Lynch suture at the same time of the caesarean section.

09922 Increased Procedural Services: When the work required to provide a service is substantially greater then typically required, it may be identified with modifier -22 (09922) to the usual procedure code. **Documentation must support the substantial additional work and the reason for the additional work (ie., increased intensity, time, technical difficulty of procedure, severity of the patient's condition, physical and mental effort required).** Note: This modifier should not be appended to an E/M service.

Assign 59899 Unlisted procedure, maternity care and delivery for the application of a B-Lynch suture during a separate surgical theatre event.

When to code a caesarean section versus a hysterotomy?

 **DSN**1501 **Pregnancy with abortive outcome**

Abortion
An abortion is generally defined as the delivery or loss of the products of conception up to and including the twenty-second (22nd) week of gestation.

Apply the guideline for abortion and assign a code for hysterotomy if ≤ 22 weeks and a code for caesarean section if > 22 weeks for an intrauterine death.

Which code should be assigned for a surgical evacuation of a blighted ovum?
59840 (Induced abortion, by dilation and curettage) is the appropriate code to be assigned for a surgical evacuation of a blighted ovum.

Coding a vaginal repair in theatre following a vaginal delivery
Assign 59300 (Episiotomy or vaginal repair, by other than attending medical doctor) for the suturing of an episiotomy, vaginal tear or laceration performed in theatre following a vaginal delivery.
It is not necessary to add the modifier 09959.

SSCS 6000 **Endocrine System** (60000 – 60699)

Guideline for Trans-sphenoidal drainage of the Pituitary Gland

The notes in the Endocrine chapter refer the coder to the Neurosurgery chapter for procedures carried out on the Pituitary gland (an endocrine gland).
Within that chapter, (the Neurosurgery chapter), the trans-sphenoidal drainage of this endocrine gland would need to be coded as an "unlisted procedure, nervous system", in the absence of both a specific code for this procedure, as well as the absence of an unlisted neuro-endoscopy code.
Should either an unlisted neuro-endoscopy code, or a specific code for this procedure become available in any future publication of the coding books, that code would take precedence over the "unlisted procedure, nervous system", in the coding of this procedure.

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SSCS 6100 **Nervous System** (61000 – 64999)

CSSA codes for injections within the Spine and Spinal Cord section should be used for pain management rather than the administration of an anaesthetic.

Codes for facet joint injection and epidural injections should be assigned if this is the reason for admission. These codes can be used for data management.

Endoscopic laminectomy

Codes **63020, 63030, and 63035** apply to procedures performed via open or endoscopically assisted techniques, requiring open and direct visualisation – typically using magnified video along with fluoroscopic guidance.
If the procedure is performed with direct visualisation (e.g., magnified video is used and billed), whether by open or endoscopic assistance, then codes 63020, 63030 and 63035 are appropriate.

As per the 2026 Coders' Desk Reference for procedures, the approaches represented by these codes may be open or endoscopically assisted, which still requires open and direct visualisation.

If the procedure is done percutaneously with only indirect visualisation (e.g., via fluoroscopy, CT, or microscope), then Codes 0274T or 62330 should be used.
Codes 0274T and 62330 involve endoscopic techniques but rely on indirect visualisation through fluoroscopy and CT, performed via percutaneous access using a small incision for the insertion of surgical instruments.

Which code/s should be assigned for a micro-discectomy?

- 63020 (Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical) **and**
- 63030 (Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar) should be assigned for a micro-discectomy.

Coding of dural leak during spinal surgery and decompression procedures

A repair of a dural leak is integral to the spinal procedure if it occurs during the spinal procedure. Codes 63707 (Repair of dural/cerebrospinal fluid leak, not requiring laminectomy) and 63709 (Repair of dural/cerebrospinal fluid leak or pseudomeningocele, with laminectomy) are therefore not assigned in addition to the spinal procedure.
For data purposes, in the South African environment, assign an additional code for the dural repair performed during spinal surgery or decompression procedures.

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Coding of a dural leak during spinal surgery:
If a dural leak occurs during a spinal procedure, repair of the dural leak should be coded to 63707 or 63709.

Example 1:
Patient had a posterior laminectomy and decompression for spinal stenosis L4/L5 and L5/S1. A dural leak occurred during spinal surgery and had to be repaired.

PPX: 63017 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g. spinal stenosis), more than 2 vertebral segments; lumbar
SPX: 63707 Repair of dural/cerebrospinal fluid leak, not requiring laminectomy

Example 2:
Patient had a posterior laminectomy for decompression with repair of a pseudomeningocele and dural graft T2/T3.

PPX: 63003 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g. spinal stenosis), 1 or 2 vertebral segments; thoracic
SPX: 63709 Repair of dural/cerebrospinal fluid leak or pseudomeningocele, with laminectomy
SPX: 63710 Dural graft, spinal

Coding of a dural leak in Cranial surgery:
If a dural leak occurs during a skull base approach procedure, repair of the dural leak should be coded to 61618 or 61619:

- 61618 Secondary repair of dura for cerebrospinal fluid leak, anterior, middle or posterior cranial fossa following surgery of the skull base; by free tissue graft (e.g. pericranium, fascia, tensor fascia lata, adipose tissue, homologous or synthetic grafts)
- 61619 Secondary repair of dura for cerebrospinal fluid leak, anterior, middle or posterior cranial fossa following surgery of the skull base; by local or regionalised vascularised pedicle flap or myocutaneous flap (including galea, temporalis, frontalis or occipitalis muscle)

If a dural leak occurs during burr hole, craniotomy or craniectomy procedure, repair of the dural leak should be coded to 62100:

- 62100 Craniotomy for repair of dural/cerebrospinal fluid leak, including surgery for rhinorrhea/otorrhea

SSCS 6500 **Eye and Ocular Adnexa** (65091 – 68899)

Removal of corneal stitches under microscope
The following CCSA code is appropriate to use for the removal of corneal stitches under microscope:
15851 Removal of sutures or staples requiring anaesthesia (i.e. general anaesthesia, moderate sedation)

SSCS 6900 **Auditory System (69000 – 69979)**

There are no specific South African data standards for this section

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SSCS 7000 **Radiology (70000 – 79999)**

Capturing of this information is at the individual healthcare provider or healthcare funder discretion based on business requirements.

Guideline for:
CPT® / CCSA Code 76872 Ultrasound, transrectal;

- This code is not gender specific, it can be assigned for both male and female patients.

SSCS 8000 **Pathology and Laboratory (80047 – 89398)**

There are no specific South African data standards for this section

Capturing of this information is at the individual healthcare provider or healthcare funder discretion based on business requirements.

SSCS 9000 **Medicine (90281 – 99607)**

Capturing of this information is at the individual healthcare provider or healthcare funder discretion based on business requirements.

Coding Cardiopulmonary Resuscitation (CPR) performed during a theatre event.

A code for CPR should be assigned if performed during a theatre event. **Modifier (09953)** must be assigned where appropriate.

Example 1:
Planned procedure discontinued as patient arrested. CPR performed in theatre.

PPX: 58953 Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking;
SPX: 09953 Discontinued Procedure
SPX: 92950 Cardiopulmonary resuscitation (e.g. in cardiac arrest)

Example 1:
Patient arrested after anaesthesia. No incision was made. CPR performed in theatre.

PPX: 92950 Cardiopulmonary resuscitation (e.g. in cardiac arrest)
SPX: 58953 Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking;
SPX: 09953 Discontinued Procedure

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SSCS 000U **Proprietary Laboratory Analyses Codes (0001U – 0599U)**

This range of codes should be disregarded in the SA environment.

SSCS 000F **Category II Codes**

This range of codes should be disregarded in the SA environment.

SSCS 000T **Category III Codes**

This section contains a set of temporary codes for emerging technology, services, procedures and service paradigms. Category III codes allow data collection for these services/procedures. Use of unlisted codes does not offer the opportunity for the collection of specific data. If a Category III code is available, this code must be reported instead of a Category I unlisted code. This is an activity that is critically important in the evaluation of health care delivery and the formation of public and private policy. The use of the codes in this section allows medical doctors and other qualified health care professionals, insurers, health services researches and health policy experts to identify emerging technology, services, and procedures and service paradigms for clinical efficacy, utilisation and outcomes.[10]

- The CCSA Coding Standards and Guidelines should apply per section, or code as documented above or in the CCSA manuals.

Example 1:
The patient underwent MR-guided focused ultrasound ablation for the destruction of uterine leiomyomata.

PPX: 0071T (Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue)

Example 2:
The patient underwent a transnasal oesophagogastroduodenoscopy (EGD). Biopsy specimens were obtained during the examination and submitted for pathological analysis.

PPX: 0653T (Oesophagogastroduodenoscopy, flexible, transnasal; with biopsy, single or multiple)

[10] Complete CPT® for South Africa (CCSA) 2018 Edition, Volume II

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Unlisted CPT®/CCSA Code Requests approved by the Technical Working Group

Disclaimer: The *PHISC Complete CPT® for South Africa (CCSA) Coding Standards and Guidelines* document is updated and published annually. Any new additions to the defined list of codes or standards are subject to review and approval by the PHISC Clinical Coding Subcommittee. Please note that approved changes will only be incorporated into the next scheduled annual update and interim versions will not be published to reflect new codes or standards.

Decisions concerning unlisted codes will be formalised through official PHISC communication. Unless stated otherwise, they will take effect three (3) months after the communication date, giving stakeholders sufficient time to implement the required changes.

Exceptional circumstances that may justify a departure from the standard implementation period, including urgent queries about listed codes, must be referred to the PHISC Clinical Coding Subcommittee for discussion and agreement.

Some services or procedures performed by medical practitioners or other qualified healthcare professionals may not be listed in CCSA. Specific codes are therefore designated for reporting unlisted procedures. However, when a more specific listed CCSA code is available, it must be used instead of an unlisted code.

- **When there are two possible unlisted codes for one procedure, where one indicates the approach and the other indicates the anatomical site, then the approach should take precedence.**
  The ICD-10 diagnosis code will reflect the specific site.

Reference: GPCS 0003 Unlisted Procedure or Service, PHISC CCSA Coding Standards and Guidelines document.

Date requested:	27/09/2016
Request:	Which code should be assigned for a complete excision of the fourth rib (R) side? None of the other CCSA codes are appropriate. This is for an injury that resulted in a total excision of the rib.
Approach:	Open
Device(s) used:	None
Decision:	Assign the unlisted code 21899
Date agreed:	06/10/2016

Date requested:	26/04/2017
Request:	Which is the appropriate unlisted CCSA code for a laparoscopic pancreatectomy?
Approach:	Laparoscopic
Device(s) used:	None
Decision:	Assign the unlisted code 49329
Date agreed:	27/09/2017

Date requested:	30/08/2021
Request:	Review: Which is the appropriate unlisted CCSA code for a laparoscopic liver biopsy?
Approach:	Laparoscopic
Device(s) used:	None
Decision:	Assign 47379
Date agreed:	28/09/2021

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Date requested:	03/07/2017
Request:	Which is the appropriate CCSA code for a laparoscopic retroperitoneal lymphadenectomy with frozen section?
Approach:	Laparoscopic
Device(s) used:	None
Decision:	Assign 38589
Date agreed:	16/05/2018

Date requested:	23/07/2018
Request:	How should the Venous External Support (VEST) procedure be coded?
Approach:	Open
Device(s) used:	External stent
Decision:	Assign 33999
Date agreed:	17/10/2018

Date requested:	17/10/2019
Request:	Can we use the unlisted code 47379 (Unlisted laparoscopic procedure, liver) for a laparoscopic liver resection?
Approach:	Laparoscopic
Device(s) used:	None
Decision:	Assign the unlisted code 47379
Date agreed:	23/10/2019

Date requested:	21/10/2019
Request:	Which code should be used for the laparoscopic uterosacral nerve ablation (LUNA) procedure?
Approach:	Laparoscopic
Device(s) used:	None
Decision:	Assign the unlisted code 64999
Date agreed:	20/07/2022

Date requested:	
Request:	Can we assign 49322 for the laparoscopic drainage of a liver cyst?
Approach:	Laparoscopic
Device(s) used:	None
Decision:	Assign 49322
Date agreed:	26/10/2019

Date requested:	21/01/2020
Request:	Which code should be assigned for a transcatheter Potts procedure?
Approach:	Transcatheter
Device(s) used:	None
Decision:	Assign 37501
Date agreed:	21/10/2020

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Date requested:	
Request:	Request to use CCSA code 97799 (Unlisted physical medicine/rehabilitation service or procedure) to indicate admissions for rehabilitation.
Approach:	
Device(s) used:	None
Decision:	This is a funder requirement. CCSA code 97799 will be accepted in the secondary position together with 99199. Some hospitals may not accept this code as the primary diagnosis.
Date agreed:	20/05/2020

Date requested:	
Request:	Which code should be assigned for a laparoscopic biopsy of the spleen?
Approach:	Laparoscopic
Device(s) used:	None
Decision:	Assign 38129
Date agreed:	21/10/2020

Date requested:	10/06/2020
Request:	Which code should be assigned for a laparoscopic repair of a gastric ulcer?
Approach:	Laparoscopic
Device(s) used:	None
Decision:	Assign 43659
Date agreed:	21/10/2020

Date requested:	10/06/2020
Request:	Which code should be assigned for a laparoscopic repair of a duodenal, gastroduodenal or gastrojejunal ulcer, or an ulcer that starts in the stomach and extends to the intestines?
Approach:	Laparoscopic
Device(s) used:	None
Decision:	Assign 44238
Date agreed:	21/10/2020

Date requested:	14/08/2020
Request:	Which code should be assigned for an endoscopic septoplasty?
Approach:	Endoscopic
Device(s) used:	None
Decision:	Assign 30999
Date agreed:	21/10/2020

Date requested:	10/06/2021
Request:	Which CCSA code can one use for the ligation of a per-anal artery?
Approach:	
Device(s) used:	None
Decision:	Assign 37799
Date agreed:	21/07/2021

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Date requested:	18/06/2021
Request:	Which CCSA code can one use for the ligation of uterine arteries?
Approach:	Open
Device(s) used:	None
Decision:	Assign 37799
Date agreed:	21/07/2021

Date requested:	22/07/2021
Request:	How is an arthroscopic Lemaire reconstruction of the knee coded?
Approach:	Arthroscopic
Device(s) used:	None
Decision:	Assign 29999
Date agreed:	03/11/2021

Date requested:	13/07/2022 – updated 21/05/2026
Request:	Which CPT®/CCSA code should be assigned for video-assisted thoracoscopic surgery (VATS) diaphragmatic hernia repair?
Approach:	Video-assisted thoracoscopic
Device(s) used:	None
Decision:	Assign 39599
Date agreed:	20/04/2023 – updated 21/05/2026

Date requested:	13/07/2022 – updated 21/05/2026
Request:	Which CPT®/CCSA code should be assigned for video-assisted thoracoscopic surgery (VATS) bronchopleural fistula repair?
Approach:	Video-assisted thoracoscopic
Device(s) used:	None
Decision:	Assign 32999
Date agreed:	20/04/2023 – updated 21/05/2026

Note: VATS Pnuemolysis is accommodated by 32652 (Thoracoscopy, surgical; with total pulmonary decortication, including intrapleural pneumonolysis)

Date requested:	03/10/2023
Request:	Which CPT®/CCSA code should be assigned for a vaginoscopy?
Approach:	Vaginoscopy
Device(s) used:	None
Decision:	Assign 58999
Date agreed:	20/04/2023

Date requested:	19/04/2024
Request:	Which code should be assigned for an endoscopic transforaminal lumbar interbody fusion (TLIF)?
Approach:	Endoscopic
Device(s) used:	None
Decision:	Assign the unlisted code 22899
Date agreed:	17/07/2024

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Date requested:	20/05/2026
Request:	Which CCSA code should be assigned for an endoscopic ultrasound (EUS) retroperitoneal lymph node biopsy?
Approach:	Endoscopic
Device(s) used:	None
Decision:	See 43242 and notes below coding of an endoscopic ultrasound (EUS)
Date agreed:	20/05/2026

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Definitions, Acronyms and Abbreviations

Intervention
An action to help treat or cure a condition.

Procedure
A procedure is defined as any clinical healthcare intervention.

Relative Value Unit (RVU)
Value assigned to a procedure based on the difficulty and time consumed. Used for computing reimbursement under a relative value study[11].
Relative Value Units (RVU's) are allocated to most CCSA codes.
RVU's are used by some Healthcare Practitioners in South Africa for billing.

Tariff[12]
Any schedule of prices or fees.

Abbreviation	Term / Definition
AMA	American Medical Association
CPT®	Current Procedural Terminology
CCSA	Complete CPT® for South Africa
ICD-10	International Statistical Classification of Diseases and Related Health Problems 10th Revision
NAPPI	National Pharmaceutical Product Index
PHISC	Private Healthcare Information Standards Committee
PPX	Primary Procedure
RVU	Relative Value Unit
SAMA	South African Medical Association
SPX	Secondary Procedure
HCPCS	Healthcare Common Procedure Coding System

[11] Reference: 2013 Coders' Desk Reference for Procedures
[12] Farlex dictionary

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Appendix A

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Appendix B

Refer to PHISC CCSA Business Case

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