The Private Practice Billing Framework: Rules, Modifiers, and Compliance Guide for Radiographers and Sonographers

Time-Based tariff codes:

- 50% Time Rule
- Minimum Billable Increment: 15 minutes
- Continuous Scanning/Screening Time (e.g., Fluoroscopy 39167): Subject to Rule 005. Billed per 30 minutes or part thereof, provided the additional part comprises 50% or more (15 minutes or more) of the next time block.
- Theatre & Attendance Time (39169 / 39179): Governed strictly by operational availability. Billed per half hour or part thereof. Any operational fraction leaking into the next block legally justifies the next unit, as your equipment and staff are actively tied up in a sterile environment.

Practical Examples of the Time Rule in Action

To show how a total case time of **1 hour and 20 minutes (80 minutes total)** splits across different codes:

Example A: Theatre Attendance & C-Arm (Codes 39169 / 39179)

- **Block 1 (0–30 mins):** 1st Unit used.
- **Block 2 (31–60 mins):** 2nd Unit used.
- **Block 3 (61–90 mins):** You are 20 minutes into this block. Because theatre time is billed per half hour *or part thereof* based on operational tie-up, that 20-minute spill over legally triggers the next block.
- **Total Units Billed: 3 Units**

Example B: Continuous Fluoroscopy Screening (Code 39167)

- **Block 1 (0–30 mins):** 1st Unit used.
- **Block 2 (31–60 mins):** 2nd Unit used.
- **Block 3 (61–90 mins):** You are 20 minutes into this block. Because continuous screening is subject to Rule 005, you check the 50% threshold (15 minutes). Since 20 minutes is greater than or equal to 15 minutes, you are legally entitled to claim this block.

- **Total Units Billed: 3 Units**

What if the screening time was 1 hour 10 minutes (70 minutes total)? > For **Theatre (39169/39179)**, the 10-minute spill over still counts as a "part thereof" and you bill **3 units**. For **Screening (39167)**, the 10-minute spill over fails to hit the 15-minute (50%) threshold, meaning you are strictly capped at **2 units**.

Add-On Codes:

- Add-on codes are usually not billed alone and must be linked to a primary procedure.
- Explanation
  If **Yes**: Must be linked to a primary examination or procedure.
  If **No**: Can be billed as a standalone examination

Standalone Billing Allowed:

- If **No**: Claim may reject if billed without primary procedure.
- If **Yes**: Claim may reject if Incorrect body part, duplicate billing, or missing authorization.

Portable/Theatre Fees:

- Portable and theatre fees are supplementary charges added to the main study.

Fluoroscopy Time:

- Fluoroscopy codes are billed according to procedural time.

Cath Lab Procedures:

- Interventional and catheterisation procedures are often billed in 30-minute units.

Repeat Examinations:

- Repeat examinations often require medical justification.

Multiple Examination Rules:

- When multiple body parts are imaged, reduced fees or modifiers may apply.

Tomography Add-Ons:

- Tomography additions are supplementary to the primary examination.

Primary Procedure Requirement:

- Many add-on codes require a valid primary procedure on the same claim.

Medical Schemes:

- All Medical schemes will pay the claimed amount subject to the Scheme benefit rules, available funds and benefits.
- Not all tariff codes / modifiers are covered by medical schemes.

CRITICAL FOR SONOGRAPHERS (Sub-discipline 004)

Please ensure your sub-discipline is fully registered with the BHF, and forward this proof to all medical schemes during your provider registration. Taking this step will drastically reduce the risk of claims being rejected under Code 66 ('Service not funded by specialty')

Modifiers

Based strictly on the foundational BHF/NHRPL operational layout, individual medical scheme rule books, list of modifiers that diagnostic radiographers and sonographers can use in South African private practice.

390001 - Emergency Call-Out Fee

(Most medical schemes do not cover this fee.)

"The specified call-out fee may be charged for any bona fide, justifiable emergency occurring at any hour which requires the practitioner to travel to the patient."

The Strict Rules for Claiming 390001

Medical scheme forensic systems watch this code incredibly closely. To avoid an immediate rejection or a retroactive payment reversal, the claim must satisfy three strict clinical parameters:

- **You Must Physical Travel:** You cannot bill 390001 if you were already at the hospital/rooms finishing off routine daytime scans. It explicitly requires that an emergency call was placed, and you had to physically travel from your home or out-of-office location back to the facility to perform the examination.
- **Justifiable Emergency:** The clinical scenario must dictate immediate diagnostic necessity. It cannot be used for elective, scheduled, or "convenience" scanning that could have waited until normal business hours.
- **The Time Factor:** While the modifier text says "occurring at any hour," schemes will cross-reference the time stamp of this line with your primary scanning codes (e.g., your emergency DVT ultrasound 5113 or trauma X-ray views).

How to Structure it on the Invoice

Modifier 390001 does not multiply the value of your scans like percentage modifiers do. Instead, it carries its own fixed Rand value (assigned as a standard unit conversion factor by the BHF annually) which acts as a flat "inconvenience/travel fee" added to the bill.

On your billing platform, it is listed as its own distinct line item:

- **Line 1:** 390001 (Emergency Call-Out Fee) **Pays a flat statutory fee**
- **Line 2:** 5113 (Doppler Ultrasound - if sub-discipline 004) **Pays 100%**

Audit-Proofing Tip: If you append 390001 to an invoice, ensure that the corresponding **ICD-10 diagnostic code** is a clear trauma, acute emergency, or critical care code (e.g., acute appendicitis, internal haemorrhage, or severe acute trauma), and ensure that your written clinical report explicitly mirrors the urgent medical necessity of the call-out.

0021 – Services rendered to hospital patients

Modifier 0021 is purely a location and tracking indicator. It acts as a flag for the medical scheme's automated clearing engine to signal that the service did not take place as an outpatient in your private rooms, but rather as an inpatient service at a hospital or an admitted patient in a day clinic.

What Does Modifier 0021 Mean?

When you append Modifier 0021 to a billing code, it fundamentally alters how the medical scheme's switching system processes the claim line:

- **Directs Pay-out from the Hospital Benefit:** It tells the scheme to pay the claim out of the patient's Core Hospital Benefit (Major Medical Expenses) rather than exhausting their daily day-to-day savings account or out-of-hospital limits.
- **Triggers Event Linking:** The scheme's system will look to match your claim with the hospital's actual admission data or the authorization number. If a patient was never admitted, a line item with 0021 might reject because there is no matching hospital event. Always capture the authorization number of the hospital admission.

0080 - Multiple examinations: Full fees

The Core Meaning: No Sliding Scale Reduction
In most medical disciplines (like surgery or general practitioners), if a clinician performs multiple procedures on a patient during a single session, a sliding scale or "reduction rule" is applied.

Modifier 0080 completely overrides this reduction for diagnostic radiographers.
When you perform multiple distinct diagnostic X-ray or imaging examinations on the same patient during the same visit, Modifier 0080 dictates that **every single examination must be paid out at 100% (Full Fees) of the scheme rate.** There is no downward scaling or penalty for efficiency.

Why Does Modifier 0080 Exist?
The rule acknowledges the physical reality of a radiographer's workflow:

- If a polytrauma patient comes into your rooms requiring X-rays of the hand, the wrist, and the forearm, each of those views requires completely distinct anatomical positioning, separate image capturing, individual processing, and separate clinical documentation.
- Because the operational workload, time, and physical equipment output do not decrease for the subsequent regions scanned, the pricing structure protects the practice by keeping every code at its full value.

Practical Billing Example 1
If you take a series of plain film X-rays for a patient who injured multiple areas in an accident:

- Line 1: 39003 (Hand X-ray) Paid at 100%
- Line 2: 39003 (Wrist X-ray) Append Modifier 0080 Paid at 100%
- Line 3: 39003 (Forearm X-ray) Append Modifier 0080 Paid at 100%

Practical Billing Example 2

The Bilateral Feet Component. Your request specifies a comprehensive 3-view series (AP, Lat, Oblique) for *both* the left and right feet.
According to the rules for code 39003 (Limb per region, e.g., foot), an adjacent part that does not require an additional set of views should not be added. However, because the left foot and right foot are completely separate anatomical regions requiring entirely separate setups, positionings, and image captures, they must both be billed, utilizing Modifier 0080 to claim full fees.

Left Foot (3 Views)

- **Code: 39003** (Limb per region - Foot)
- **Modifier: 0080** (Multiple examinations: Full fees)
- **Fee Structure: 100%** of your private practice rate.

Right Foot (3 Views)

- **Code: 39003** (Limb per region - Foot)
- **Modifier: 0080** (Multiple examinations: Full fees)
- **Fee Structure: 100%** of your private practice rate.

By appending 0080 to the subsequent lines, you are instructing the medical aid's automated electronic claims processor: *"These are distinct multiple examinations on different anatomical regions, not a double-submission or duplicate error. Pay full fees."*

The Ultrasound (Sub-discipline 004) Catch-22
Most major private medical aid rule engines (like Discovery Health or Medscheme) have built-in clinical restrictions for ultrasound. The scheme's internal policy often forces a 50% reduction on the second code anyway, utilizing their own specific rules for matching ultrasound bundles.

Best Practice: Always consult your billing software's specific rule validation layer for the specific scheme you are claiming from. If you are billing multiple soft-tissue ultrasounds under 004, ensure the scheme doesn't require a dedicated clinical motivation or separate times logged to clear their internal duplicate-rejection blocks.

0081 - Repeat examinations: No reduction

This modifier is to protect your revenue when you are forced to repeat a examination of the *same* anatomical region.

What Does Modifier 0081 Mean in Practice?
Normally, if a medical aid clearing engine sees two identical tariff codes on the same invoice for the same date of service, it immediately auto-rejects the second line as a **"Duplicate Claim Error."**

Modifier 0081 is a regulatory instruction to the medical scheme that says: *"The second examination is not a duplicate data-entry mistake. It was a clinically necessary repeat examination of the exact same area, and it must be paid at 100% full fees without any sliding-scale reduction."*

When is Modifier 0081 Used?
This modifier is highly operational in dynamic clinical situations where a baseline image is no longer sufficient due to changes in the patient's state or the physical procedure itself.

Clinical Scenarios for Diagnostic Radiography (Discipline 039)

- **Post-Reduction Checks:** A patient arrives in your rooms with a displaced fracture. You take a baseline X-ray (39003 - Wrist). The doctor manipulates and sets the bone (reduces the fracture) in the procedure room. You are then called back to take a *second* X-ray of the exact same wrist to confirm the bone alignment is correct.
- **Post-Intubation / Post-Line Verification:** A chest X-ray (39107) is taken. The physician inserts a central venous line or an endotracheal tube, then requests an immediate second chest X-ray to verify that the tip of the line or tube is perfectly positioned.

Clinical Scenarios for Sonography (Sub-discipline 004)

- **Vascular or Fluid Dynamic Monitoring:** An initial ultrasound is performed to check for an active internal bleed or hematoma development post-trauma. Two hours later, under a doctor's instruction, you repeat the localized scan to see if the volume of the fluid collective has expanded.
- **Immediate Post-Procedure Evaluation:** Performing a baseline ultrasound scan of a structure, assisting a clinician with an ultrasound-guided drainage or biopsy, and then immediately scanning the exact same zone again to rule out immediate localized complications (like a hematoma).

How to Structure the Invoice Line Items
To avoid an automated rejection, the repeat line item must be clearly distinct from the first line on your billing platform

- **Line 1:** Code 39107 (Chest X-ray) 100% Payment
- **Line 2:** Code 39107 + **Modifier 0081** (Repeat Chest X-ray) 100% Payment

Vetting Rule for Private Practice: While Modifier 0081 forces the medical aid system to process the full fee, it frequently acts as a soft flag for human clinical auditors. To protect against retroactive forensic reversals, **always log the exact timestamp** of both examinations on the report and state the clinical reason for the repeat (e.g., *"Repeat study captured post-reduction"* or *"Follow-up scan to check for expanding hematoma"*).

0084 - Film Costs

In everyday private practice running modern digital equipment (CR or DR), you will almost never have to manually use or type Modifier 0084 onto your invoices.

Because modern practices capture and transmit images electronically via PACS (Picture Archiving and Communication Systems) and DICOM networks to referring doctors, the physical consumable cost of old-school chemical film is gone. Medical schemes have factored this digital evolution directly into their global reimbursement rates.

However, there are **two specific clinical and operational scenarios** where this modifier is still used today in South African radiography:

True Analog Equipment & Physical Film Printing

If your practice operates in a remote area, handles specific mobile occupational health screenings, or uses an older analogue X-ray unit that still utilizes a chemical processor and physical darkroom film:

- The Application**:** You append Modifier 0084 to your skeletal or chest X-ray codes to legally claim back the volatile, high material cost of the physical film sheets given to the patient or referring doctor.

Mandatory Legal or Medico-Legal Hardcopies

Even if your practice is 100% digital, certain external entities legally demand a high-resolution, hardcopy film printout—they will not accept a CD, USB drive, or a link to a digital portal.

- The Application: When performing X-rays for Road Accident Fund (RAF) litigation, specialized High Court forensic cases, or certain state occupational health audits where a stamped, physical film is a statutory requirement.

Summary Rule of Thumb

- If it's an Ultrasound (Sub-discipline 004): Never use it.
- If it's an everyday digital X-ray for standard medical aids: Ignore it; your practice management software automatically wraps the modern equivalent into the base fee.
- If you are legally forced to hand over a physical, printed X-ray film due to analog constraints or a court subpoena: Append 0084 to get paid for that physical raw material.

0089 - Computed Tomography

Modifier 0089 is a quality-control rule used exclusively for CT scans in South Africa. It penalizes practices using outdated, low-resolution equipment by cutting their pay-out in half if the scan quality or slice count is too low.

The Two Rules to Get Paid 100%

To claim the full fee for a CT scan, the examination must meet two minimum standards:

The "Slice Count" Rule (Minimum Volume)

The scan must include at least:

- 8 slices for a Brain CT
- 12 slices for a Chest CT
- 16 slices for an Abdomen CT

The "Matrix Size" Rule (Minimum Resolution)

- The image grid must be at least 250 x 250 pixels (most modern scanners easily use 512 x 512 pixels).
- The Penalty: If the scanner is old and shoots at a resolution lower than 250, Modifier 0089 triggers, and the medical scheme cuts the fee by 50%.

Does not apply to:

- Sonographers
- General Radiographers

Summary

If you are doing CT billing, modern multi-slice scanners pass these thresholds automatically. You just need to ensure your billing software sends the scan metadata correctly so the scheme knows it was a high-resolution, full-series scan.