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 : August 2017

PHISC DISCLAIMER

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Revision History

Version	Date	By Whom	Changes
Draft 1 version 1.00	2012/02/16	Crystal Wahid	Document creation after meeting held on the 2012/01/25.
Draft 2 version 1.00	2012/02/28	Crystal Wahid	Changes to definition of procedure and primary procedure. ***This is still under discussion***. Addition of examples – pending Addition of Appendix B.
Draft 3 version 1.00	2012/02/28	Luisa Whitelaw	Note added on page 3 – CCSA training must conform to the SAMA copyright review refer to Appendix A.
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".
Draft 3 version 1.00	2012/02/28	Sithara Satiyadev	The addition of "drug" to "specific ethical drug used" to the Unlisted Procedure or Service standard.
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
Draft 4 version 1.00	2012/04/18	Penny Mekgwe	Suggestion for the Numbering System - use the numbering as per first code in that section to the nearest zero so that there is a bit of logic to the numbering.
Draft 4 version 1.00	2012/04/18	Sithara Satiyadev	Edits to the documents and the addition of SSCS 3000 Respiratory System and SSCS 6900 Auditory System.
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Draft 4 version 1.00	2012/04/28	Lynet Clarke	Addition of information on the documentation of medical records.
Draft 4 version 1.00	2012/04/30	Leonie Maritz	Addition of SSCS 3300 Cardiovascular System.
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Acknowledgement

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 / medical 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.	

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

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.

References:

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)

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).

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.

- 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

[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.

- 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

GPCS 0003 **Unlisted Procedure or Service**

It is recognised that there may be services or procedures performed by medical practitioners 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.[2]

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.[3]

- **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.**
- **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.**
- **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

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

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.[4]

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

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.

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.

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

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.[5]

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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Copyright in the Complete CPT® for South Africa (CCSA) and its contents, vest in the South African Medical Association (SAMA). Copyright in CPT® vest in the American Medical Association (AMA). Please refer to Appendix A for the terms and conditions for the use of CCSA for training purposes.

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.

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

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 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 laparoscopic cholecystectomy converted to an open cholecystectomy.
PPX: 47600 Cholecystectomy
SPX: 47652 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

09953 Discontinued Procedure: Under certain circumstances, the medical practitioner 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 modifier 09953 to the code reported by the medical practitioner 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.**

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

- 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)

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 practitioner.
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)

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

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

SSCS 3300 **Cardiovascular System** (33010 – 37799)

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

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

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

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 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).

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:
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.

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

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

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

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.

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.

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

Guideline:

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.

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.

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

Removal of corneal stitches under microscope
The following CCSA codes are appropriate to use for the removal of corneal stitches under microscope:

15850 Removal of sutures under anaesthesia (other than local), same surgeon
15851 Removal of sutures under anaesthesia (other than local), other surgeon

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

There are no specific South African data standards for this section

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

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

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

SSCS 0000F **Category II Codes (0001F – 7025F)**

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

SSCS 0000T **Category III Codes (0019T – 0259T)**

This section contains a set of temporary codes for emerging technology, services and procedures. Category III codes will 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 will allow medical practitioners and other qualified health care professionals, insurers, health service researches and health policy experts to identify emerging technology, services and procedures for clinical efficacy, utilisation and outcomes.[6]

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

Example 1:
Patient had two total disc arthroplasties performed to replace two severely damaged intervertebral discs in the lumbar region.
PPX: 22857 Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar
SPX: 0163T Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar (List separately in addition to code for primary procedure)

[6] Complete CPT® for South Africa (CCSA) 2012 Edition, Volume I

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[7].
Relative Value Units (RVU's) are allocated to most CCSA codes.
They are used by some Medical Practitioners in South Africa for billing.

Tariff[8]
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

[7] Reference: 2013 Coders' Desk Reference for Procedures
[8] Farlex dictionary

Appendix A

Terms and conditions for the Use of CCSA for training purposes

Permission was granted by the American Medical Association (AMA) to SAMA, for the use of the Complete CPT® for South Africa (CCSA), for training purposes.
The SA Medical Association (SAMA) is responsible to ensure that the copyright of the Current Procedural Terminology (CPT®) in South Africa is not infringed by any party.

Therefore:

1. SAMA must review and approve the training manual prior to final publication and distribution of same in order to ensure that no infringement of intellectual property rights has occurred. This approval will not, however, constitute a formal endorsement of the training manual by SAMA.
2. Under no circumstances may copies be made of the information or text contained in the CCSA. It is permissible to make cross references to relevant portions of the CCSA within the text of the training manual.
3. The CCSA books must be used in conjunction with the training manual. CCSA books will be made available to students at a discounted price. The discounted rate will only be applicable to students who are properly registered to participate in the training and this registration must be formally confirmed by the trainer / training company.
4. SAMA will not levy or charge any fees to provide the review and approval as referred in clause 1. The review and approval will be performed by SAMA within ten (10) working days after receipt of the manual from the trainer / training company.
5. The intellectual property in the training manual vests solely with in trainer/training company.
6. SAMA will not, under any circumstances, make any information in the training manual available to any third party.
7. Training manuals should be forwarded to SAMA on CD or in a PDF file format.
8. Training manuals forwarded to SAMA, must be version controlled. If any changes are made in the training material, a copy of the training manual must again be forwarded to SAMA for approval.

These Term and Conditions only apply to training companies, their employees, representatives, agents and sub-contractors.

Where training makes reference to the CCSA, but does not distribute, copy or lend the CCSA to the trainees, or provide a training manual containing extracts from the CCSA, these Terms and Conditions do not apply.

Appendix B

Refer to PHISC CCSA Business Case