
GOVERNMENT NOTICES • GOEWERMENTSKENNISGEWINGS

DEPARTMENT OF EMPLOYMENT AND LABOUR

NO. 4576

28 March 2024

PHYSIOTHERAPY GAZETTE 2024

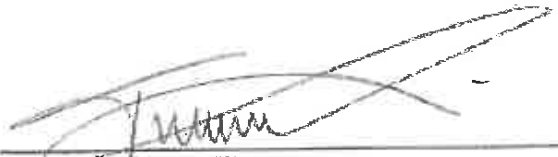
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DEPARTMENT OF EMPLOYMENT & LABOUR**NOTICE:****DATE:****COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 (ACT NO.130 OF 1993), AS AMENDED****ANNUAL INCREASE IN MEDICAL TARIFFS FOR MEDICAL SERVICES PROVIDERS.**

1. I, Thembelani Waltermade Nxesi, Minister of Employment and Labour, hereby give notice that, after consultation with the Compensation Board and acting under powers vested in me by section 97 of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No.130 of 1993), prescribe the scale of "Fees for Medical Aid" payable under section 76, inclusive of the General Rule applicable thereto, appearing in the Schedule, with effect from 1 April 2024.
2. Medical Tariffs increase for 2024/25 are as follows:
 - 2.1. HOSPITAL TARIFFS: To be increased between 0% - 9.7% as applicable
 - 2.2. Non HOSPITAL TARIFFS: 5.4%
3. The fees appearing in the Schedule are applicable in respect of services rendered from 1 April 2024 for the financial year 2024/25 and exclude 15% VAT.


MR TW NXESI, MP
MINISTER OF EMPLOYMENT AND LABOUR
DATE: 23/01/2024



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COID MEDICAL TARIFFS GENERAL INFORMATION

1. POPI ACT COMPLIANCE

In terms of Protection of Personal Information Act, 2013 (POPI Act), the Compensation Fund wants to assure Employees and the Medical Service Providers that all personal information collected is treated as private and confidential. The Compensation Fund has put in place the necessary safeguards and controls to maintain confidentiality, prevent loss, unauthorized access and damage to information by unauthorized parties.

2. THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

Medical Service Providers are advised to take note of the following as it pertains to the treatment of patients in relation to The Compensation for Occupational Injuries and Diseases Act of 1993 (COID Act):

1. An employee as defined in the COID Act of 1993, is at liberty to choose their preferred Medical Service Provider and no interference with this is permitted. As long as it is exercised reasonably and without prejudice to the employee or The Compensation Fund.
 - a. The only exception rule is in case where an employer, with the approval of The Compensation Fund, provides comprehensive medical aid facilities to his employees, i.e. including hospital, nursing and other services — Section 78 of the COID Act refers.
2. In terms of Section 42 of The COID Act, The Compensation Fund may refer an injured employee to a specialist medical practitioner, designated by the Director General for a medical examination and report.
3. In terms of section 76,3(b) of the COID Act, no amount in respect of medical expenses shall be recoverable from the employee.
4. In the event of a change of a Medical Service Provider attending to a case, the first treating doctor in attendance will, except where the case is transferred to a specialist, be regarded as the principal treating doctor.
5. To avoid disputes regarding the payment for services rendered, Medical Service Providers should refrain from treating an employee already under treatment by another medical practitioner without consulting/informing the principal treating doctor. As a general rule, changes of Medical Service Providers are not encouraged by The Compensation Fund, unless sufficient reasons exist for such a change.



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6. According to the National Health Act no 61 of 2003, Section 5, a health care provider may not refuse a person emergency medical treatment. Such a Medical Service Provider should not request The Compensation Fund to authorise such treatment before the claim has been registered and liability for the claim is accepted by The Compensation Fund.
7. An employee seeks medical advice at their own risk. If such an employee presents themselves to a Medical Service Provider as being entitled to treatment in terms of The COID Act, whilst having failed to inform their employer and/or The Compensation Fund of any possible grounds for a claim. The Compensation Fund cannot accept responsibility for the settlement of medical expenses incurred under such circumstances.
8. The Compensation Fund could have reasons to repudiate a claim lodged with it, in such circumstances the employee would be in the same position as any other member of the public regarding payment of his medical expenses.
9. Proof of identity is required in order for a claim to be registered with The Compensation Fund.
 - a. In the case of a South African citizen, a copy of a South African Identity Document.
 - b. In the case of foreign nationals, the proof of identity (Passport) must be certified.
10. All supporting documentation submitted to The Compensation Fund must reflect the identity and claim numbers of the employee.
11. The completion of medical reports cannot be claimed separately, fees quoted in the COID medical tariffs are inclusive of medical report completion.
12. The tariff amounts published in the COID medical tariffs guides, for services rendered do not include VAT unless otherwise specified. All invoices for services will therefore be assessed without VAT.
 - a. VAT will be applied without rounding off, to invoices for service providers that have confirmed their VAT vendor status through the submission of their VAT registration number.
13. All Medical Service Providers transacting with The Compensation Fund will be subject to a vetting process
14. All Medical Service Providers must ensure that they are compliant with the Board of Health Funders to avoid payments being due to them being withheld.
15. Medical Service Providers may be requested to grant The Compensation Fund access to their premises for auditing purposes.



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3. OVERVIEW OF COID CLAIMS PROCESS

All claims lodged in the prescribed manner with The Compensation Fund undergo the following process:

1. New claims are registered by the Employers with The Compensation Fund. Details and progress of the claim can be viewed on the online processing system for registered online users.
2. The allocation of a claim number after the registration of the claim by The Compensation Fund, does not constitute acceptance of liability. It confirms the injury on duty has been reported and receipt acknowledged by The Compensation Fund.
3. In the event of insufficient claim information being made available to The Compensation Fund, the claim will be rejected until the outstanding information is submitted.
 - a. Please note that there are claims on which a decision might never be taken due to the non-submission of outstanding information.
4. If a claim is repudiated in terms of the COID Act medical expenses for services rendered, will not be payable by The Compensation Fund. The employer and the employee will be informed of this decision and the injured employee will be liable for payment of medical costs incurred
5. Reasonable medical expense in terms of the COID Act, become payable subsequent to the acceptance of liability by The Compensation Fund.
 - a. Reasonable medical expense shall be paid in line with approved tariffs, billing rules and procedures published in COID medical tariffs.
 - b. Only medical treatment related to the injury/disease shall be payable.
6. Reasonable medical expenses for COID claims where liability has been accepted (adjudicated) on or after 01 April 2024:
 - a. All medical invoices for accepted claims must be submitted, in the prescribed manner within 24 months of the date of acceptance of liability. Medical invoices received after said time frame, will be considered as late submission of invoices.
 - b. Payment may be rejected/withheld for medical invoices that fail to meet the requirements as set is 6(a).



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4. COID REGISTRATION REQUIREMENTS FOR MEDICAL SERVICE PROVIDERS

The Compensation Fund requires that any Medical Service Provider who intends to treat patients in terms of the COID Act, must register this intent by following the registration process as below:

1. Copies of the following documents must be submitted to the nearest Labour Centre
 - a. A certified Identity Document of the practitioner.
 - b. Certified valid BHF certificate.
 - c. Their most recent bank statement with the bank stamp.
 - d. Proof of address not older than 3 months.
 - e. Submit SARS VAT registration number document where applicable. If this is not provided the Medical Service Provider will be registered as a Non-VAT vendor.
 - f. Submit proof of dispensing licence where applicable.
 - g. A power of attorney is required where the Medical Service Provider has appointed a third party for administration of their COID claims.
2. A duly completed original Banking Details form (WaC 33) that can be downloaded in PDF from the Department of Employment and Labour Website (www.labour.gov.za).
3. Submit the following additional information on the Medical Service Providers letterhead, Cell phone number, Business contact number, Postal address and Email address. The Compensation Fund must be notified in writing of any changes to contact details.



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5. REGISTRATION PROCESS: TO BECOME COID ONLINE SYSTEM USER FOR MEDICAL SERVICE PROVIDERS

To become an online user of the claims processing system, Medical Service Providers please do as follow steps.

1. Register as an online user with the Department of Employment and Labour on its website (www.labour.gov.za)
2. Register on the CompEasy application:
 - a. The following documents must be at hand to be uploaded
 - i. A certified copy of Identity Document (not older than a month from the date of application)
 - ii. Certified valid BHF certificate
 - iii. Proof of address not older than 3 months
 - b. In the case where a Medical Service Provider makes use of a third party to access the claims processing system on their behalf, the following ADDITIONAL documents must be uploaded
 - i. An appointment letter for proxy (the template is available online)
 - ii. The proxy's certified Identity Document (not older than a month from the date of application)
3. There are instructions online to guide a user on successfully registering (www.compeasy.gov.za)

6. REQUIREMENTS FOR THIRD PARTIES TRANSACTING WITH THE COMPENSATION FUND ON BEHALF OF MEDICAL SERVICE PROVIDERS

Third Parties that administer invoices on behalf of Medical Service Providers must comply with the following:

1. A third-party transacting with The Compensation Fund, must be capable of obtaining original claim documents and medical invoices from Medical Service Providers.
2. The third party must keep such records in their original state as received from the medical service provider and must furnish The Compensation Commissioner with such documents on request
3. The Compensation Fund shall not provide or disclose any information related to a Medical Service Provider who is contracted to a third party where such information was obtained or relates to a period prior to an agreement between Medical Service Provider and a third party.



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7. COID REQUIREMENTS WHEN BILLING FOR MEDICAL SERVICES PROVIDED TO INJURED/DISEASED EMPLOYEES

1. All service providers should be registered on The Compensation Fund claims processing system in order to capture medical invoices and medical reports.
2. Medical reports and medical invoices should **ONLY** be submitted/transmitted for claims that The Compensation Fund has accepted liability for and reasonable medical expenses are payable.
3. Medical Reports:
In terms of Sec 74(1)(2)(3)(4) and (5) of COID Act, submission of Medical Report; Medical service provider are advised to take note of the following:
 - a. The First Medical Report (W. CL 4), completed after the first consultation must confirm the **clinical** description of the injury/disease. It must also detail any procedure performed and any referrals to other medical service providers where applicable.
 - b. All follow up consultations must be completed on a Progress Medical Report (W.CL5). Any operation/procedure performed must be detailed therein and any referrals to other Medical Service Providers where applicable.
 - i. A progress medical report is considered to cover a period of 30 days, with the exception where a procedure was performed during that period, then an additional operation report will be required.
 - ii. Only one medical report is required when multiple procedures are done on the same service date.
 - c. When the injury/disease being treated stabilises, a Final Medical Report must be completed (W.CL 5F).
 - d. Medical Service Providers are required to keep copies of medical reports which should be made available to The Compensation Commissioner on demand.
4. Medical Invoices:
 - a. The ICD-10 validations will apply as per the national ICD-10 phase 3 and phase 4.1 requirements. Note that these phases were implemented on 01 July 2014 and entail the following:
 - i. Valid and ICD-10 codes as the SA ICD-10 Master Industry Table
 - ii. Maximum level of specificity: ICD-10 codes to be valid at the correct 3rd,4th Or 5th character level.
 - iii. character level.
 - iv. Valid ICD-10 primary codes, codes not valid as primary will be rejected
 - v. Comply with the dagger and asterisk rule
 - vi. Comply with the sequelae coding rules
 - vii. Age edits for ICD-10 codes that have age requirements
 - viii. Gender edits



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- ix. All injury and poisoning codes must be accompanied by external cause codes
- b. The Compensation Fund allows the submission of invoices in 3 different formats:
 - i. Switching of invoices: Medical invoices should be switched to The Compensation Fund using the approved format/ electronic invoicing file layout. It must be noted that the corresponding medical report must be uploaded online prior to the invoice data being switched, to avoid system rejections on receipt.
 - ii. Direct uploading of invoices onto the processing application (External APP): The processing system has an online guide available to guide Medical Service Providers for the direct uploading of invoice on the application.
 - iii. Receipt of manual invoices by Labour Centres.

The first two options are encouraged for ease of processing.

- c. The progress of claims/invoices may be viewed on The Compensation Funds processing system.
- d. If invoices are partially or wholly outstanding with no reason indicated after 60 days of submission, a medical service provider should enquire by completing an Enquiry Form W.Cl-20 and submit it **ONCE** to nearest Labour Centre. Details regarding Labour Centres are available on the website (www.labour.gov.za)
5. When a Medical Service Provider claims an amount less than the published tariff amount for a code, The Compensation Fund will pay the claimed amount.
6. When a Medical Service Provider claims an amount more than the published tariff amount for a code, The Compensation Fund will pay the Gazetted amount.
7. Medical Service Provider are required to keep copies of medical invoices, medical report and any other claim documents and make these available to The Compensation Commissioner on request.
8. Medical Service Provider should not generate multiple invoices for services rendered on the same date i.e. one invoice for medication and the second invoice for other services.

NOTE: Medical forms are available on the Department of Employment and Labour website (www.labour.gov.za)

- **First Medical Report (W.CL 4)**
- **Progress/Final Medical Report (W.CL 5)**



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8. MINIMUM INFORMATION REQUIRED FOR MEDICAL INVOICES SUBMITTED TO THE COMPENSATION FUND:

The following must be indicated on a medical invoice in order to be processed by The Compensation Fund

1. The allocated Compensation Fund claim number
2. Name and Identity number of the employee
3. Name and Compensation Fund registration number of Employer, as indicated on the Employers Report of Accident (W.CL 2)
4. DATES:
 - a. Date of accident
 - b. Date of service (From and to)
5. Medical Service Provider BHF practice number
6. VAT registration number of medical service provider: VAT will not be applied if a VAT registration number is not supplied on the invoice.
7. Tariff Codes:
 - a. Tariff code applicable to injury/disease, are as published tariff gazettes.
 - b. Amount claimed per code, quantity and the total amount of the invoice
8. VAT:
 - a. The tariff amounts published in the tariff guides exclude VAT.
 - b. All invoices for services rendered will be assessed without VAT.
 - c. VAT will be applied to VAT registered vendors (Medical Service Providers) without being rounded off
 - d. With the exception of the following:
 - i. "PER DIEM" tariffs for Private Hospitals that already are VAT inclusive
 - ii. Certain VAT exempted codes in the Private Ambulance tariff structure.
9. All pharmacy or medication invoices must be accompanied by copies of the original script(s)
10. Where applicable the referral letter from the treating practitioner must accompany the Medical Service Provider's invoice.
11. All medical invoices must be submitted with invoice numbers to prevent system rejections.
12. Duplicate invoices should not be submitted.
13. The Compensation Fund does not accept submission of running accounts /statements.

NOTE: The Compensation Fund will withhold payments if medical invoices do not comply with minimum submission and billing requirements as published in the Government Gazette.



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9. REQUIREMENTS FOR SWITCHING MEDICAL INVOICES TO THE COMPENSATION FUND

A switching provider must comply with the following requirements:

1. Register with The Compensation Fund as an employer where applicable in terms of the COIDA Act 1993
2. Host a secure FTP (or SFTP) server to ensure encrypted connectivity with The Compensation Fund. This requires that they ensure the following:
 - a. Disable Standard FTP because is now obsolete. ...and use latest version and reinforce FTPS protocols and TLS protocols
 - b. Use Strong Encryption and Hashing.
 - c. Place Behind a Gateway.
 - d. Implement IP Blacklists and Whitelists.
 - e. Harden Your FTPS Server.
 - f. Utilize Good Account Management.
 - g. Use Strong Passwords.
 - h. Implement File and Folder Security
 - i. Secure administrator, and require staff to use multifactor authentication
3. Submit a complete successful test file after registration before switching invoices.
4. Verify medical service provider's registration with the Board of Healthcare Funders of South Africa.
5. Submit medical invoices with gazetted COIDA tariffs that are published annually.
6. Comply with medical billing requirements of The Compensation Fund.
7. Single batch submitted must have a maximum of 150 medical invoices.
8. Eliminate duplicate invoices before switching to the Fund.
9. File name must include a sequential batch number in the file naming convention.
10. File names to include sequential number to determine order of processing.
11. Only pharmacies should claim from the NAPPI file.

NOTE: Failure to comply with the above requirements will result in deregistration/penalty imposed on the switching house.



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COMPEASY ELECTRONIC INVOICING FILE LAYOUT

*** Mandatory fields**

FIELD	DESCRIPTION	MAX LENGTH	DATA TYPE	MANDATORY
BATCH HEADER				
1	Header identifier = 1	1	Numeric	*
2	Switch internal Medical aid reference number	5	Alpha	
3	Transaction type = M	1	Alpha	
4	Switch administrator number	3	Numeric	
5	Batch number	9	Numeric	*
6	Batch date (CCYYMMDD)	8	Date	*
7	Scheme name	40	Alpha	*
8	Switch internal	1	Numeric	
DETAIL LINES				
1	Transaction identifier = M	1	Alpha	*
2	Batch sequence number	10	Numeric	*
3	Switch transaction number	10	Numeric	*
4	Switch internal	3	Numeric	
5	CF Claim number	20	Alpha	*
6	Employee surname	20	Alpha	*
7	Employee initials	4	Alpha	*
8	Employee Names	20	Alpha	*
9	BHF Practice number	15	Alpha	*
10	Switch ID	3	Numeric	
11	Patient reference number (account number)	11	Alpha	*
12	Type of service	1	Alpha	
13	Service date (CCYYMMDD)	8	Date	*
14	Quantity / Time in minutes	7	Decimal	*
15	Service amount	15	Decimal	*
16	Discount amount	15	Decimal	*
17	Description	30	Alpha	*
18	Tariff	10	Alpha	*
19	Service fee	1	Numeric	
20	Modifier 1	5	Alpha	
21	Modifier 2	5	Alpha	
22	Modifier 3	5	Alpha	
23	Modifier 4	5	Alpha	
24	Invoice Number	10	Alpha	*
25	Practice name	40	Alpha	*
26	Referring doctor's BHF practice number	15	Alpha	
27	Medicine code (NAPPI CODE)	15	Alpha	*
28	Doctor practice number -sReferredTo	30	Numeric	
29	Date of birth / ID number	13	Numeric	*



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FIELD	DESCRIPTION	MAX LENGTH	DATA TYPE	MANDATORY
30	Service Switch transaction number – batch number	20	Alpha	
31	Hospital indicator	1	Alpha	*
32	Authorisation number	21	Alpha	*
33	Resubmission flag	5	Alpha	*
34	Diagnostic codes	64	Alpha	*
35	Treating Doctor BHF practice number	9	Alpha	
36	Dosage duration (for medicine)	4	Alpha	
37	Tooth numbers		Alpha	*
38	Gender (M, F)	1	Alpha	
39	HPCSA number	15	Alpha	
40	Diagnostic code type	1	Alpha	
41	Tariff code type	1	Alpha	
42	CPT code / CDT code	8	Numeric	
43	Free Text	250	Alpha	
44	Place of service	2	Numeric	*
45	Batch number	10	Numeric	
46	Switch Medical scheme identifier	5	Alpha	
47	Referring Doctor's HPCSA number	15	Alpha	*
48	Tracking number	15	Alpha	
49	Optometry: Reading additions	12	Alpha	
50	Optometry: Lens	34	Alpha	
51	Optometry: Density of tint	6	Alpha	
52	Discipline code	7	Numeric	
53	Employer name	40	Alpha	*
54	Employee number	15	Alpha	*
55	Date of Injury (CCYYMMDD)	8	Date	*
56	IOD reference number	15	Alpha	
57	Single Exit Price (Inclusive of VAT)	15	Numeric	
58	Dispensing Fee	15	Numeric	
59	Service Time	4	Numeric	
60				
61				
62				
63				
64	Treatment Date from (CCYYMMDD)	8	Date	*
65	Treatment Time (HHMM)	4	Numeric	*
66	Treatment Date to (CCYYMMDD)	8	Date	*
67	Treatment Time (HHMM)	4	Numeric	*
68	Surgeon BHF Practice Number	15	Alpha	
69	Anaesthetist BHF Practice Number	15	Alpha	
70	Assistant BHF Practice Number	15	Alpha	
71	Hospital Tariff Type	1	Alpha	

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FIELD	DESCRIPTION	MAX LENGTH	DATA TYPE	MANDATORY
72	Per diem (Y/N)	1	Alpha	
73	Length of stay	5	Numeric	*
74	Free text diagnosis	30	Alpha	
TRAILER				
1	Trailer Identifier = Z	1	Alpha	*
2	Total number of transactions in batch	10	Numeric	*
3	Total amount of detail transactions	15	Decimal	*



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MSPs PAID BY THE COMPENSATION FUND

DISCIPLINE CODE:	DISCIPLINE DESCRIPTION:
004	Chiropractors
009	Ambulance Services - Advanced
010	Anesthesiology
011	Ambulance Services - Intermediate
012	Dermatology
013	Ambulance Services - Basic
014	General Medical Practice
015	General Medical Practice
016	Obstetrics and Gynecology (Occupational related cases)
017	Pulmonology
018	Specialist Medicine
019	Gastroenterology
020	Neurology
021	Cardiology (Occupational Related Cases)
022	Psychiatry
023	Medical Oncology
024	Neurosurgery
025	Nuclear Medicine
026	Ophthalmology
028	Orthopaedic
030	Otorhinolaryngology
034	Physical Medicine
035	Emergency Medicine Independent Practice Speciality
036	Plastic and Reconstructive Surgery
038	Diagnostic Radiology
039	Radiography
040	Radiation Oncology
042	Surgery Specialist
044	Cardio Thoracic Surgery
046	Urology
049	Sub-Acute Facilities
052	Pathology
054	General Dental Practice
055	Mental Health Institutions
056	Provincial Hospitals
057	Private Hospitals
058	Private Hospitals
059	Private Rehab Hospital (Acute)



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060	Pharmacy
062	Maxillo-facial and Oral Surgery
064	Orthodontics
066	Occupational Therapy
070	Optometry
072	Physiotherapy
075	Clinical Technology (Renal Dialysis only)
076	Unattached operating theatres / Day clinics
077	Approved U O T U / Day clinics
078	Blood transfusion services
079	Hospices/Frail Care
082	Speech Therapy and Audiology
083	Hearing Aid Acoustician
084	Dietician
086	Psychology
087	Orthotists & Prosthetics
088	Registered Nurses (Wound Care only)
089	Social Worker
090	Clinical Services: (Wheelchairs and Gases only)
094	Prosthodontic

PHYSIOTHERAPY TARIFF OF FEES AS FROM 1 APRIL 2024 (PRACTICE TYPE 072)	
General Rules	
Rule	Rule Description
001	Unless timely steps are taken (at least two hours) to cancel an appointment for a consultation the relevant consultation fee shall be payable by the employee.
003	Newly hospitalised patients will be allowed up to 20 sessions without pre - authorisation. If further treatment is necessary after a series of 20 treatment sessions for the same condition, the treating medical practitioner must submit a pre-authorisation request with a treatment plan to the Compensation Fund for authorisation. Hospitalised patients admitted to ICU and High Care following an emergency will not require authorisation for rehabilitation services. Referral letter from the Medical Doctor with the initial treatment plan and progress report should be submitted with the invoice. All the cases are subject to case management.
004	AM and PM treatment sessions, applicable only to hospitalised patients, should be specified and medically motivated for on the Annexure F (Motivation for twice a day Physiotherapy).
005	Out - patients will be allowed up to 10 sessions without pre-authorization. If further treatment is necessary after a series of 10 treatment sessions for the same condition, the treating doctor must submit a motivation with treatment plan to the Compensation Fund for authorisation. The Physiotherapist must submit monthly progress report. Modifier 0015 must be quoted.
006	"After hour treatment" shall mean all physiotherapy performed where emergency treatment and /or essential continuation of care is required after working hours, before 07:00 and after 17:00 on weekdays, and any treatment over a weekend or public holiday. In cases where the Physiotherapist's scheduled working hours extend after 17:00 and before 07:00 during the week or weekend, the above rule shall not apply and the treatment fee shall be that of the normal listed tariff. The fee for all treatment under this rule shall be the total fee for the treatment plus 50 percent. Modifier 0006 must then be quoted after the appropriate tariff code to indicate that this rule is applicable. Where emergency treatment is provided: a. during working hours, and the provision of such treatment requires the practitioner to leave his or her practice to attend to the patient in hospital; or b. after working hours, the fee for such visits shall be the total fee plus 50%. a. "emergency treatment" means a bona fide, justifiable emergency physiotherapy procedure, where failure to provide the procedure immediately would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy; and b. "working hours" means 8h00 to 17h00, Monday to Friday.
007	The Physiotherapist shall submit his / her account for treatment directly to the Fund using available electronic means.
008	When an employee is referred for physiotherapy treatment after a surgical procedure, a new treatment plan needs to be provided to the Fund.
009	When more than one condition requires treatment and each of these conditions necessitates an individual treatment, they shall be charged as individual treatments. Full details of the nature of the treatments and the diagnosis or diagnostic codes shall be stated. Modifier 0009 must be quoted.

010	When the treatment times of two completely separate and different conditions overlap, the fee shall be the full fee for one condition and 50% of the fee for the second condition. Both conditions must be specified. Modifier 0010 must then be quoted after the appropriate code number to indicate that this rule is applicable.
011	Cost of material does not include consumables (e.g. ultrasound gel, massage oil, gloves, alcohol swabs, facial tissues, paper towels and etc.)
012	An invoice for services rendered will be assessed and added without VAT. VAT is then calculated and added to the final payment amount.
013	When a physiotherapist performs treatment away from the treatment rooms, travelling costs being more than 16 kilometres in total, to be charged at R4,84 per km for each kilometre travelled in own car e.g. 19 km total = 19X R4,84 = R91.96. If more than one employee is attended to during the course of a trip, the full travelling expenses must be pro rata between the relevant employees (the physiotherapist will claim for one trip). A Physiotherapist is not entitled to charge any travelling expenses or travelling time to his / her rooms. Modifier 0013 must be quoted.
014	Physiotherapy services rendered in a hospital, Modifier 0014 must be quoted after each tariff code.
015	The services of a Physiotherapist shall be approved only on referral from the treating medical practitioner. Where a Physiotherapist's letterhead is used as a referral letter, it must bear the medical practitioner's signature, date and stamp. The referral letter for any physiotherapy treatment provided should be submitted to the Compensation Commissioner with the account for such services.
016	Physiotherapists, Occupational Therapists and Chiropractors may not provide simultaneous treatment at the same time on a day, but may treat the same patient. Multidisciplinary treatment goals must be considered and the best placed service provider to achieve the rehabilitation goal must address that specific goal.
Modifiers	
Abbreviation	Description
AM	Additional Modifier
IM	Information Modifier
RM	Reduction Modifier
Modifier	Modifier Description
0006	AM: Emergency Modifier - Add 50% of the total fee for the treatment. Refer to Rule 006
0009	AM: Treatment of two separate conditions. Refer to Rule 009
0010	RM: Only 50% of the fee for the second condition may be charged. Refer to rule 010
0013	AM: Travelling costs (being more than 16 kilometers in total), Refer to rule 013
0014	IM: Physiotherapy services rendered in hospital patients. Refer to Rule 014
0015	IM: Physiotherapy services rendered as an out-patient. Refer to rule 005

Tariff Codes		
Note	Only one of the following codes can be claimed per session/consultation: 72925,72926,72327,72921,72923,72928,72927,72501 and 72503	
Code	Code Description	Rand
1.	Rehabilitation	
72501	Rehabilitation where the pathology requires the undivided attention of the Physiotherapist. Duration: 30min. This code can only be claimed once per treatment session	559.44
72503	Rehabilitation for Central Nervous System disorders - condition to be clearly stated and fully documented (No other treatment modality may be charged in conjunction with this). Duration: 60min. This code can only be claimed once per treatment session	1119.07
72509	Rehabilitation. Each additional full 15 mins needs to be medically motivated with a clear indication where pathology requires the undivided attention of the Physiotherapist. Tariff code 72509 can be added to 72501 and 72503.	178.98
2.	Evaluation	Rand
72701	Applies to simple evaluation once at first visit only. It should not be used for each condition. A treatment plan / rehabilitation progress report must be fully documented and submitted at the initiation of treatment. Tariff code 72701 cannot be used with 72702	322.24
72702	Complex evaluation once at first visit only. Applies to complex injuries only. It should not be used for each condition. A treatment plan / rehabilitation progress report describing what makes the evaluation complex, must be fully documented and submitted at the initiation of treatment. Tariff code 72702 cannot be used with 72701	482.91
72703	One complete re - assessment or one physical performance test during the course of treatment. To be used only once per episode of care. This should be fully documented and a rehabilitation progress report provided to the Compensation Fund. This tariff code will apply to patients that have been discharged and are now re - admitted if there has been a gap in treatment or during the course of his treatment to ensure treatment goals and outcomes are aligned.	160.70
3.	Visiting	
72901	Consultation: Treatment at a hospital: Relevant fee plus (to be charged only once per day).	117.75
72903	Consultation: Domiciliary treatments: Apply only when medically motivated and pre -authorised: relevant fee plus.	214.26

4.	Other	Rand
72939	Cost of material item to be charged (exclusive of VAT) as per attached Annexure A for consumables and Annexure B for equipment. When claiming 72939 a list of materials used must be quoted in an accompanying report NOTE: Where the net acquisition price is under a hundred rand 26% has been applied. Where the net acquisition price is equal or above one hundred rand a maximum of R26.00 has been added.	
72925	Level 1 chest pathology, which includes either or / and: > Vibration > Percussion > Nebulisation > Suction: Level 1 (including sputum specimen taken by suction) <i>Applies to non - ventilated patients only</i>	527.55
72926	Level 2 chest pathology which includes either or / and: > Vibration > Percussion > Postural drainage > Upper respiratory nebulisation and/or lavage > Suction: Level 2 (Suction with involvement of lavage as a treatment in a special unit situation or in the respiratory compromised patient) e.g. Tracheostomy > Pre - and post - operative exercises and/or breathing <i>Applies to High Care and non - ventilated patients</i>	871.66
72327	Level 3 chest pathology which includes either or / and: > Vibration > Percussion > Postural drainage > Upper respiratory nebulisation and/or lavage > Intermittent positive pressure ventilation > Suction: Level 2 (Suction with involvement of lavage as a treatment in a special unit situation or in the respiratory compromised patient) > Bagging (used on the intubated unconscious patient or in the severely respiratory distressed patient) > Pre - and post - operative exercises and/or breathing exercises, applies for ventilated patients only.	1106.54
72921	Simple spinal treatment which includes either or / and: MANIPULATION/MOBILISATION OF JOINTS OR IMMOBILISATION which includes either or / and: > Spinal (Manual spinal mobilisation) > Pre meditated manipulation > Immobilisation (excluding materials) > Pre - and post - operative exercises and/or breathing exercises	774.74

72923	Complex spinal treatment which includes either or / and: MANIPULATION/MOBILISATION OF JOINTS OR IMMOBILISATION which includes either or / and: > Spinal (Manual spinal mobilisation) > Pre meditated manipulation > Immobilisation (excluding materials) > Rehabilitation for Central Nervous System disorders - condition to be clearly stated and fully documented (No other treatment modality may be charged in conjunction with this) > Traction > Pre- and post-operative exercises and/or breathing exercises	1119.07
72928	Simple soft tissue / peripheral joint injuries or other general treatment which includes either or / and: > Massage > Neural tissue mobilisation > Pre - and post - operative exercises and/or breathing exercises	774.74
72927	Complex soft tissue / peripheral joint injuries or other general treatment > Massage > Myofascial release/soft tissue mobilisation, one or more body parts > Neural tissue mobilisation > Pre - and post - operative exercises and/or breathing exercises	1011.94

ANNEXURE A**LIST OF CONSUMABLES****To be used with code 72939****Service providers may add on 20% for storage and handling**

Name of Product	Unit	Approx Unit Price(excl Vat)
Tubigrip (A & B white)	1	32.46
Self adhesive disposable electrodes (one set per employee is payable)	1	103.10
Sports		
<i>Taping / Strapping (type & quantity must be specified)</i>		
Elastoplast 75mm x 4.5	1	201.53
Coverol	1	156.60
Leukotape	1	201.53
Magic Grip Spray	1	152.77
Fixomull	1	172.32
Leukoban 50-75mm x 4.5m	1	86.10
Other		
Incontinence electrodes for pathway EMG	1	415.96
EMG flat electrodes (should be medically justified)	1	41.64

ANNEXURE B**LIST OF EQUIPMENT/APPLIANCES**

Service providers may add on 20% for storage and handling

Equipment not payable if the same were already supplied by an Orthotist /
Prosthetist to the same employee.

Name of Product	Unit	Approx Unit Price (excl Vat)
Hot / cold packs	1	305.52
Braces		
Cervical collar	1	170.69
Lumbar brace	1	623.41
Standard heel cups	pair	206.87
Cliniband	1	78.48
Fit band 5.5cm	1	19.90
Fit band 30cm	1	69.78
Peak flow meter	1	390.57
Peak flow meter	2	4.85
Spirometer	1	394.90

ANNEXURE C**PART 1 – INITIAL EVALUATION AND PLAN**

EMPLOYEE DETAILS							
Claim number							
First Name/s			Surname				
Identity Number			Mobile No.				
Address			Postal Code				
EMPLOYER DETAILS							
Name							
Address			Postal Code				
ACCIDENT DETAILS							
Date of Accident							
REFERRING MEDICAL PRACTITIONER DETAILS							
Name			Practice No.				
Referral date							
PHYSIOTHERAPIST'S DETAILS							
Name							
Practice No.			Account No.				
1. First Consultation Date	D		D		M		M
NOTE: For sections 2 to 6, please provide evidence from objective assessment results e.g. if the patient initially presented with pain, please provide the score from the pain measure used, such as the Borg scale, if the patient initially presented with limited ROM at a particular joint, please provide the initial, current and anticipated joint range measurements in degree.							
2. Indicate initial clinical presentation:							
3. Indicate patient's symptoms and function:							
4. Indicate any complicating factors that may prolong rehabilitation or delay recovery:							
5. Treatment goals							
6. Treatment Plan for proposed treatment session							
Codes Requested:				Number of sessions per Code Requested:			
Name and Signature of Physiotherapist				Date			

ANNEXURE D**PART 2 – TREATMENT AND PROGRESS (MONTHLY)**

EMPLOYEE DETAILS			
Claim Number			
First Name/s		Surname	
Identity Number		Mobile No.	
Address		Postal Code	
EMPLOYER DETAILS			
Name			
Address		Postal Code	
ACCIDENT DETAILS			
Date of Accident			
REFERRING MEDICAL PRACTITIONER DETAILS			
Name		Practice No.	
Referral date			
PHYSIOTHERAPIST'S DETAILS			
Name			
Practice No.		Account No.	
1. No. of sessions already provided:			
Start Date:		End date:	
2. No. of sessions currently being requested			
NOTE: For sections 3 to 6, please provide evidence from objective assessment results e.g. if the patient initially presented with pain, please provide the score from the pain measure used, such as the Borg scale, if the patient initially presented with limited ROM at a particular joint, please provide the initial, current and anticipated joint range measurements in degree.			
3. Progress Achieved: RELATE YOUR PROGRESS TO YOUR OUTCOME MEASURES STATED IN PART 1 REPORT			
4. Did the patient undergo surgical procedure during this treatment period?	Yes	No	
5. If yes, state surgical procedure date/s and procedure/s done:			
6. Treatment Plan for proposed treatment session/s:			
Codes Requested	Number of sessions per code Requested		

7. Referral to another Medical Service Provider:			
Reason for Referral -		☐	Patient prefers another service provider
		☐	More convenient for Patient to treated closer to home
		☐	Referral to Specialist
		☐	Referral to another Rehabilitation Practitioner
		☐	Clinical Vocational Rehabilitation
		☐	Other
Contact details of the Practitioner patient is referred to:			
Designation			
Work telephone no.			
Mobile no.			
Email address			
Name and Signature of Physiotherapist		Date	

ANNEXURE E**PART 3 – FINAL PROGRESS REPORT**

EMPLOYEE DETAILS													
Claim number													
First Name/s					Surname								
Identity Number					Mobile No.								
Address					Postal Code								
EMPLOYER DETAILS													
Name													
Address					Postal Code								
ACCIDENT DETAILS													
Date of Accident													
REFERRING MEDICAL PRACTITIONER DETAILS													
Name					Practice No.								
Referral date													
PHYSIOTHERAPIST'S DETAILS													
Name													
Practice No.					Account No.								
1. No. of sessions already provided													
Start Date:	Y	Y	M	M	D	D	End date:	Y	Y	M	M	D	D
2. Date of Final Treatment:													
NOTE: For sections 3 to 6, please provide evidence from objective assessment results e.g. if the patient initially presented with pain, please provide the score from the pain measure used, such as the Borg scale, if the patient initially presented with limited ROM at a particular joint, please provide the initial, current and anticipated joint range measurements in degree.													
3. Progress Achieved: RELATE YOUR PROGRESS TO YOUR OUTCOME MEASURES STATED IN PART 1 & 2 REPORT													
4. Is the employee fit for his/her normal work?													
				Yes				No					
5. Is the employee fully rehabilitated/ has the employee obtained highest level of function?													
				Yes				No					
6. If No, describe in detail any present permanent anatomical defect and / or impairment of function as a result of the accident.													
7. Referral to another Medical Service Provider:													
Reason for Referral				Patient prefers another service provider More convenient for Patient to treated closer to home Referral to Specialist Referral to another Rehabilitation Practitioner Clinical Vocational Rehabilitation Other									
Contact details of the Practitioner patient is referred to													
Designation				Work telephone no.									
Email address				Mobile no.									
Name and Signature of Physiotherapist				Date									

ANNEXURE F**PHYSIOTHERAPISTS'S MOTIVATION FOR MORE THAN ONE PHYSIOTHERAPY
TREATMENT PER DAY**

EMPLOYEE DETAILS:			
Date:		Claim number	
Patient Name:			
Referring Doctor:			
Identification No			
Date of injury:			
Claim No.:			
Diagnosis:			
Reason for B.D Physiotherapy			
	Deterioration / Alteration in Patient's Respiratory Condition.		
	Poor Mobility, Reduced Musculo - Skeletal Strength, decrease Range of Movement and /or Reduced Exercise Tolerance		
	Gait difficulties - including poor balance and coordination.		
	Complicated Medical case with multiple injuries		
	General deterioration of the patient's condition.		
	Requiring maximal assistance (usually 2 physiotherapists) with Activities of daily Living / Physiotherapy in order to regain Functional Independence due to his Condition / diagnosis.		
	Other - please specify:		
Name and Signature of Physiotherapist		Date	