DEPARTMENT OF EMPLOYMENT AND LABOUR

NOTICE 3049 OF 2025

RADIOGRAPHY & DIETICIAN GAZETTE 2025

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Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

Compensation Fund, Delta Heights Building 167 Thabo Sehume Street, Pretoria 0001
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NOTICE: **DATE:**

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASSES ACT, 1993 (ACT NO.130 OF 1993), AS AMENDED

ANNUAL INCREASE IN MEDICAL TARIFFS FOR MEDICAL SERVICES PROVIDERS.

1. I, Nomakhosazana Meth, 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 2025.
2. Medical Tariffs will increase by 6% for the financial year 2025/26.
3. The fees appearing in the Schedule are applicable in respect of services rendered from 1 April 2025 and exclude 15% VAT

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Ms. N Meth, MP

MINISTER OF EMPLOYMENT AND LABOUR

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GENERAL INFORMATION

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, unauthorised access and damage to information by unauthorised parties.

1. MEDICAL SERVICE PROVIDERS REGISTRATION REQUIREMENTS WITH THE COMPENSATION FUND

1.1. The Compensation Fund requires that any Medical Service Provider, providing medical treatment to patients in terms of the COID Act, must be registered with The Compensation Fund as follows:

1.1.1. 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. Recent bank statement with bank stamp or bank letter

d. Proof of practice address not older than 3 months.

e. Submit SARS VAT registration number/ certificate if VAT registered. If this is not provided the Medical Service Provider will be registered as a Non VAT vendor.

f. A power of attorney is required where the MSP has appointed a third party for administration of their COID claims.

1.1.2. 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).

1.1.3. Submit the following additional information on the Medical Service Provider letterhead, Cell phone number, Business contact number, Postal address and Email address. The Fund must be notified in writing of any changes in order to effect necessary changes.

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Employment and Labour
REPUBLIC OF SOUTH AFRICA

2. REGISTERING WITH THE COMPENSATION FUND AS AN ONLINE SYSTEM USER FOR MEDICAL SERVICE PROVIDERS

2.1. To register as an online user of the claims processing system, COMPEASY, the following steps must be followed:

2.1.1. Register as an online user with the Department of Employment and Labour website (www.labour.gov.za)

2.1.2. Register on the CompEasy application having the following documents to upload:

- A certified copy of identity document (not older than a month from the date of application)
- Certified valid BHF certificate
- Proof of address not older than 3 months

2.2. In the case where a medical service provider wishes to appoint a proxy to interact on the claims processing system the following ADDITIONAL documents must be uploaded:

- An appointment letter for proxy (the template is available online)
- The proxy's certified identity document (not older than a month from the date of application)
- There are instructions online to guide a user on successfully registering (www.compeasy.gov.za)

3. THIRD PARTIES TRANSACTING ON BEHALF OF MEDICAL SERVICE PROVIDERS

3.1. Third Parties that provide administration services on COID medical invoices on behalf of medical service providers must take note of the following:

3.1.1. A third party transacting with the Fund, must be in a position to obtaining a copies of the original claim documents and medical invoices from medical service providers.

3.1.2. 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 for the purposes of auditing.

3.2. The Fund will not provide or disclose any information related to a medical service provider, represented by a third party, where such information was obtained or relates to a period prior to them contracting to a third party.

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Employment and Labour
REPUBLIC OF SOUTH AFRICA

4. THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

4.1. 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):

4.1.1. An employee as defined in the COID Act of 1993, is at liberty to choose their preferred medical service provider without interference, as long as it is exercised reasonably and without prejudice to the employee or the Compensation Fund.

4.1.2. The only exception to this rule is in case where an employer, with the approval of the Compensation Fund, provides comprehensive medical aid facilities to its employees, e.g. Hospital, nursing and other medical services — Section 78 of the COID Act refers.

4.1.3. In terms of Section 42 of the COID Act, the Compensation Fund may refer an injured employee to a specialist medical service provider designated by the Director General for a medical examination and report.

4.1.4. In terms of section 76,3(b) of the COID Act, no amount in respect of medical expenses shall be recoverable from the employee.

4.1.5. 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.

4.1.6. 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.

4.1.7. Any changes of medical service providers must have sufficient reasons existing for such a change which must be communicated to the Compensation Fund.

4.1.8. 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.

4.1.9. 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.

4.1.10. The Compensation Fund may 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 their medical expenses.

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Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

5. OVERVIEW OF THE COID CLAIMS PROCESS

5.1. All claims lodged in the prescribed manner with the Compensation Fund are subjected to the following process:

5.1.1. New claims are registered by the Employers with the Compensation Fund in the prescribed manner. Details of and progress of the claim can be viewed on the online processing system for registered users of the system.

5.1.2. Proof of identity is required in the form of a copy of an Identity document/card, will be required in order for a claim to be registered with the Compensation Fund. In the case of foreign nationals, the proof of identity (passport) must be certified.

5.1.3. All supporting documentation submitted to the Compensation Fund must reflect the identity and claim numbers of the employee.

5.1.4. The allocation of a claim number to a claim after the registration thereof by the Compensation Fund, does not constitute acceptance of liability for a claim. It indicates that the injury on duty has been reported to the Compensation Fund and acknowledged.

5.1.5. When liability for a claim is accepted by the Compensation Fund in terms of the COID Act, reasonable medical expenses, related to the medical condition shall be paid to medical service providers, that treat the employees, in accordance to approved tariffs, billing rules and procedures as published in the medical tariff gazettes of the Compensation Fund.

5.1.6. If a claim is repudiated in terms of the COID Act, medical expenses, 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.

5.1.7. 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 and liability can be determined.

5.1.8. Manner of payment of medical benefits for Compensation Fund claims, where liability has been accepted (adjudicated) on or after 1 April 2025.

5.1.9. 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 and may be rejected.

5.1.10. All service providers should be registered on the Compensation Fund claims processing system in order to capture medical invoices and medical reports for medical services rendered.

5.1.11. Medical reports and medical invoices should ONLY be submitted/transmitted for claims that The Compensation Fund has accepted liability for and thus reasonable medical expenses are payable.

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Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

6. BILLING REQUIREMENTS FOR MEDICAL SERVICES PROVIDED TO INJURED/DISEASED EMPLOYEES

6.1. 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:

6.1.1. 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.

6.1.2. 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.

6.1.3. 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.

6.1.4. Only one medical report is required when multiple procedures are done on the same service date.

6.1.5. When the injury/disease being treated stabilises a Final Medical Report must be completed (W.CL 5F).

6.1.6. Medical Service Providers are required to keep copies of medical reports which should be made available to the Compensation Commissioner when requested.

NB: Hospitals will be required from the 1st April 2025 to provide patient records when submitting medical invoices for services provided.

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Employment and Labour
REPUBLIC OF SOUTH AFRICA

7. MINIMUM INFORMATION REQUIREMENTS 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 ID number of 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 (MSP's) 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 the original script(s)

NB!! All pharmaceuticals will be processed in accordance with Nappi file codes.

10. Where applicable the referral letter from the treating practitioner must accompany the medical service providers' invoice.
11. All medical invoices must be submitted with invoice numbers to prevent system rejections.
12. Duplicate invoices should not be submitted.
13. Compensation Fund does not accept submission of running accounts /statements, but will reject upfront at switch level.

PLEASE 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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Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

8. REQUIREMENTS FOR SWITCHING MEDICAL INVOICES WITH 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 COID Act 1993
2. Host a secure FTP (or SFTP) server to ensure encrypted connectivity with the 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 your administrator, and require staff to use multifactor authentication.
3. Submit and complete successful test file after registration before switching the 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.

PLEASE NOTE:

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

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Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

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	*
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	

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REPUBLIC OF SOUTH AFRICA

FIELD	DESCRIPTION	Max Length	DATA TYPE	MANDATORY
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	
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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REPUBLIC OF SOUTH AFRICA

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)
060	Pharmacy
062	Maxillo-facial and Oral Surgery
064	Orthodontics
066	Occupational Therapy
070	Optometry
072	Physiotherapy
075	Clinical technology (Renal Dialysis and Perfusionists only)

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Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

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	Dietetics
086	Psychology
087	Orthotics & Prosthetics
088	Registered nurses (Wound Care and Nephrology only)
089	Social worker
090	Clinical services : (Wheelchairs and Gases only)
094	Prosthodontic

RADIOGRAPHY GAZETTE 2025

RADIOGRAPHY TARIFF OF FEES AS FROM 1 APRIL 2025 (PRACTICE TYPE 039)		
DIAGNOSTIC PROCEDURES		
General Rules		
Rule	**Rule Description**	
001	**Note**:Items 015,029,031,033,037,065,071,075,077,079,081,087,089,115, 117,119,121,129,135, 137,139 and167 should be only be paid on condition that the radiographer submits the name of the supervising clinician and his/her BHF practice number.	
002	Radiographer invoices will only be paid on condition that there is a referral letter from a treating practitioner.	
Modifiers		
Modifier	**Modifier Description and Standards**	**Rand**
Addition Modifier (AM)	This modifier will add a value by using a percentage value or a unit value to a procedure code. The modifier should be quoted on a separate line with its own value instead of adding its value to the code.	
Compound Modifiers (CM)	The modifier should be quoted on a separate line with its own value at the end of the invoice instead of adding its value to the code. It should be indicated on each procedure code where the modifier is applicable.	
Reduction Modifiers (RM)	This modifier reduces the value of a procedure code/s by using a percentage or unit value.It should be quoted on the procedure codes where the modifier is applicable.	
Information Modifier (IM)	This modifier provides additional information to a procedure code and carries no financial value. It should be indicated on each procedure codes where the modifier is applicable.	
M0001	AM: Emergency fee	**87.14**
M0021	IM: Services rendered to hospital patients: Quote modifier 0021 on all accounts for services performed on hospital or day clinic patients.	
M0080	IM: Multiple examinations: Full fees	
M0081	IM: Repeat examinations: No reduction	
M0084	IM: Film Cost : The cost of film is included in the comprehensive procedure codes and is not billed separately	
Tariff Codes		
Code	**Code Description**	**Rand**
1.	**Skeleton**	
1.1	**Limbs**	
39001	Finger, toe	**284.56**
39201	Limb per region, e.g. Shoulder, (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**400.53**
39202	Limb per region, e.g. Elbow (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**361.32**
39203	Limb per region, e.g. Knee (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**382.21**
39204	Limb per region, e.g. Foot, (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**322.21**
39205	Limb per region, e.g. Hand (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**354.50**
39206	Limb per region, e.g. Wrist (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand	**365.78**

39207	Limb per region: Ankle (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**382.21**
39208	Limb per region: Scaphoid (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**379.97**
39209	Limb per region: Radius and ulna (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**338.52**
39210	Limb per region: Humerus (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**338.52**
39211	Limb per region: Acromio-Clavicula joint (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**361.32**
39212	Limb per region: Clavicle (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**350.25**
39213	Limb per region: Scapula (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**350.25**
39214	Limb per region: Calcaneus (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**315.40**
39215	Limb per region: Tibia and Fibula (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**338.52**
39216	Limb per region: Patella (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**318.86**
39217	Limb per region: Femur (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**338.52**
39218	Limb per region: Hip (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**365.78**
39219	Limb per region: Sesamoid Bone (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand).	**322.21**
39005	Smith-Petersen or equivalent control, in theatre Use once per sitting	**948.60**
39007	Stress studies, e.g. joint	**359.73**
39009	Length studies per right and left pair of long bones Only use once for both pair of bones.	**490.92**
1.2	**Spinal Column**	
39017	Per region, e.g. cervical, sacral, coccygeal, one region thoracic Code can be used multiple times for different anatomical sites of the spine.	**197.09**
39301	Cervical Spine - 2 or more views	**531.92**
39302	Per region, e.g. Sacral	**499.80**
39303	Per region, e.g. Coccygeal	**499.80**
39304	Thoracic Spine 2 Views	**398.85**
39305	Lumbar Spine - 2 or more views	**554.04**
39021	Stress studies	**70.88**
39027	Pelvis (sacro-iliac or hip joints only to be added where an extra set of views is required).	**407.14**

	Myelography	
39029	Lumbar	**303.96**
39031	Thoracic	**282.70**
39033	Cervical	**418.88**
39035	Multiple (lumbar, thoracic, cervical): Same fee as for first segment (no additional introduction of contrast medium) Refer to general rule 001.	**-**
39037	Discography (Refer to general rule 001)	**221.93**
1.3	**Skull**	
39039	Skull studies	**429.10**
39041	Paranasal sinuses	**407.14**
39043	Facial bones and/or orbits	**437.00**
39045	Mandible	**407.14**
39047	Nasal bone	**265.85**
39049	Mastoid: Bilateral	**798.25**
1.3.1	**Teeth**	
39051	One quadrant	**222.39**
39053	Two quadrants	**281.42**
39055	Full mouth	**263.41**
39057	Rotation tomography of the teeth and jaws	**451.53**
39059	Temporo-mandibular joints: Per side	**395.75**
39061	Tomography: Per side	**214.84**
39063	Localisation of foreign body in the eye	**395.75**
39065	Ventriculography (Refer to general rule 001)	**263.76**
39067	Post-nasal studies: Lateral neck	**177.78**
39069	Maxillo-facial cephalometry	**173.60**
39071	Dacryocystography (Refer to general rule 001)	**156.20**
2.	**Alimentary Tract**	
39075	Pharynx and oesophagus (Refer to general rule 001)	**160.69**
39077	Oesophagus, stomach and duodenum (control film of abdomen included) and limited follow through (Refer to general rule 001).	**221.93**
39079	Small bowel meal (control film of abdomen included, except when part of tariff code 39081) (Refer to general rule 001).	**195.32**
39081	Barium meal and dedicated gastro-intestinal tract follow through (including control film of the abdomen, oesophagus, duodenum, small bowel and colon) (Refer to general rule 001).	**332.89**
39087	Gastric/oesophageal/duodenal intubation control (Refer to general rule 001)	**146.52**
3.	**Chest**	
39105	Larynx (tomography included)	**298.96**
39107	Chest (tariff code 39167 included)	**429.80**
39109	Chest and cardiac studies (tariff code 39167 included)	**162.79**
39111	Ribs	**479.41**
39113	Sternum or sterno-clavicular joints	**562.03**

3.1	**Bronchography**	
39115	Unilateral (Refer to general rule 001)	**228.09**
39117	Bilateral .Cannot be used with tariff code 39115 (Refer to general rule 001)	**398.54**
39119	Pleurography (Refer to general rule 001)	**110.73**
39121	Laryngography (Refer to general rule 001)	**110.73**
39123	Thoracic inlet	**284.44**
4.	**Abdomen**	
39125	Control films of the abdomen (not being part of examination for barium meal, pyelogram, etc.).	**369.15**
39127	Acute abdomen or equivalent studies	**595.95**
5.	**Urinary Tract**	
39129	Control film included and bladder views before and after micturition (Refer to general rule 001)	**472.44**
39135	Cystography only or urethrography only (retrograde) (Refer to general rule 001)	**265.04**
5.1	**Cysto-Urethrography**	
39137	Retrograde (Refer to general rule 001)	**233.32**
39139	Retrograde-prograde pyelography (Refer to general rule 001)	**298.96**
39143	Tomography of renal tract: Add to item for examination performed	**135.13**
6.	**Tomography and Cinematography**	
39151	Tomography (conventional except where otherwise specified): Add 100% provided that if it is more than one dimension, fees shall be charged for the additional investigation at 50% of the rate with a maximum of two additional investigations.	-
39153	Tomography (multi-dimensional in motion): Add 150%	-
7.	**Computed Tomography**	
Modifier governing this specific section of the Tariffs		
Modifier	**Modifier Description**	
M0089	RM: The number of sections of each examination and the matrix number must be specified. A full series of sections would be 8 or more for brain examinations, 12 or more for chest examinations, and 16 or more for abdomen examinations. Fees for examinations on a matrix number of less than 250 shall be reduced by 50%.	
39155	Head, single examination, full series	**1,851.88**
39157	Head, repeat examination at the same visit, after contrast, full series	**635.58**
39159	Chest	**2,140.97**
39161	Abdomen (including base of chest and/or pelvis)	**2,488.39**
39163	Multiple examinations: For an additional part, the lesser fee shall be reduced to 50%	**578.76**
39165	Limbs and other limited examinations	**578.76**

8.	**Miscellaneous**	
39167	Fluoroscopy: Per half hour: Add to item for examination performed (not applicable to tariff code 39107 and 39109) (Refer to Rule 001) Reflect time on the invoice.	**151.05**
39169	Where a C-arm portable x-ray unit is used in hospital or theatre: Per half hour: Add to item for examination performed Reflect time on the claim or invoice.	**208.57**
39179	Attendance at operation in theatre or at radiological procedure performed by a surgeon or physician in x-ray department except 005: Per 1/2 hour: Plus fee for examination performed Reflect time on the claim or invoice.	**124.09**
39181	Setting of sterile trays Use tariff code 39181 once per sitting regardless of the number of procedures done.	**21.15**
39300	X-Ray films (Refer to modifier 0084)	**-**
	Attendance In Catheterisation Laboratory	
	Use codes 191 to 192 to charge for radiographer input where that is not included in cath lab facility fee.	
39191	Preparation in catheterisation laboratory for purposes of invasive intravascular procedures.	**303.15**
39192	Post-processing in catheterisation laboratory for purposes of invasive intravascular procedures.	**303.15**
39199	Vascular Study per 30 minutes or part thereof provided that such part comprises 50% or more of the time Reflect time on the claim or invoice.	**303.15**
Rules		
Z	No fee to be subject to more than one reduction	
9.	**Portable Unit Examinations**	
39185	Where portable x-ray unit is used in the hospital or theatre: Add to tariff code for examination performed.	**136.76**
39187	Theatre investigations with fixed installation : Add to tariff code for examination performed.	**58.45**

DIETICIAN GAZETTE 2025

DIETICIAN TARIFF OF FEES AS FROM 01 APRIL 2025 (PRACTICE TYPE 084)		
General Rules		
Rule	**Rule Description**	
001	Referral by the principal doctor with a copy of the referral letter is required.Only one visit per day and a maximum of 7 (seven) visits per claim are allowed. Motivation letter is required if more than seven visits are required.	
003	Dietary services are per individual patient.	
011	Compilation of reports: To be used to motivate for therapy and give a progress report, where such a report is specifically required by the Compensation Fund.	
Modifiers		
Modifier	**Modifier Description**	
0021	IM: Services to hospital inpatients: Quote modifier 0021 on all invoices for services performed on hospital inpatients.	
Tariff Codes		
Code	**Code Description**	**Rand**
1.	**Individual Assessment,Counselling and/or Treatment**	
84206	Initial hospital visit: Nutritional assessment, counselling and/or treatment. Duration: 61-70min. Report is required and item includes compilation of report. The relevant modifier applies.	**876.79**
84201	Follow up hospital visit in the ward: Nutritional assessment, counselling and/or treatment. Duration: 11-20min. Report is required and item includes compilation of report. The relevant modifier applies.	**187.77**
84203	Hospital follow up visit in ICU and High Care Unit: Nutritional assessment, counselling and/or treatment. Duration: 31-40min. Report is required and item includes compilation of report. The relevant modifier applies.	**563.77**
84205	Final hospital visit: Nutritional assessment, counselling and/or treatment. Duration: 51-60min. For discharge menu planning and counselling. Final report is required and item includes compilation of report. The relevant modifier applies.	**688.68**

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