DEPARTMENT OF EMPLOYMENT AND LABOUR

NO. 7258 20 March 2026

PHYSIOTHERAPY GAZETTE 2026

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Compensation Fund
WORKING FOR YOU

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, 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 2026.

2. Medical Tariffs will increase by 6% for the financial year 2026/27.

3. The fees appearing in the Schedule are applicable in respect of services rendered from 1 April 2026 and exclude 15% VAT

Ms. N Meth, MP

MINISTER OF EMPLOYMENT AND LABOUR

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GENERAL INFORMATION

1. MEDICAL SERVICE PROVIDERS REGISTRATION REQUIREMENTS WITH THE COMPENSATION FUND

- The Compensation Fund requires that any Medical Service Provider, treating patients in terms of the COID Act, must be registered with The Compensation Fund through the submission of copies of the following documents to the nearest labour centre:
  a. A duly completed original Banking Details form (WAC 33) (download in PDF from www.labour.gov.za)
  b. The latest copy of valid BHF certificate
  c. Recent bank statement with bank stamp or bank letter
  d. Proof of practice address not older than 3 months.
  e. SARS VAT registration number/ certificate if VAT registered. (If this is not provided the medical practitioner will be registered as a non-VAT vendor)
  f. A power of attorney is required if the MSP has appointed a third party to do their administration of their COID claims.

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

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

  a. Register as an online user with the Department of Employment and Labour website (www.labour.gov.za)
  b. 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)
     - Latest copy of valid BHF certificate
     - Proof of address not older than 3 months

- In the case where a medical service provider has appointed a third party to administer their COID claims with the Fund, 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)

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3. THIRD PARTIES TRANSACTING ON BEHALF OF MEDICAL SERVICE PROVIDERS

- Third Parties that provide administration services on behalf of medical service providers must take note of the following:
  - **a.** They must be able to obtain and make available copies of the original claim documents and medical invoices from medical service providers.
  - **b.** They 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.
- The Fund will not provide or disclose any information related to a medical service provider, represented by a third party, where such information relates to a period prior to them being contracting to a third party.

4. THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

Medical Service Providers are encouraged to take note of the following guidance when treating patients in terms of the Compensation for Occupational Injuries and Diseases Act of 1993 (COID Act):

- **a.** Employees as defined in the COID Act of 1993, are generally free to choose their preferred Medical Service Provider, provided that such choice is exercised reasonably and without prejudice to the employee or the Compensation Fund.
  - An exception applies 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, as contemplated in Section 78 of the COID Act, in such cases, treatment arrangements may differ.
- **b.** 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. Medical Service providers should cooperate with such referrals where they occur.
- **c.** Medical Service Providers are reminded that in accordance with section 76(3)(b) of the COID Act, medical expenses may not be recovered from the employee. Providers should therefore avoid billing employees directly for services that fall within accepted COID claims.
- **d.** Where a change of Medical Service Providers occurs, the first treating doctor is generally regarded as the principal treating doctor, unless the case is transferred to a specialist.
- **e.** To promote continuity of care and avoid disputes, Medical Service Providers are encouraged not to treat an employee who is already under the care of another practitioner without first consulting or informing the principal treating doctor.
- **f.** Any changes of medical service providers should be supported by sufficient reasons, and such reasons should be communicated to the Compensation Fund to ensure clarity and proper case management.
- **g.** In line to section 5 of the National Health Act no 61 of 2003, a health care provider may not refuse a person emergency medical treatment. In emergency situations, Medical Service Providers are not required to obtain prior authorisation from the Compensation Fund before rendering such treatment even if the claim has not yet been registered or accepted.

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h. Employees who seek medical treatment do so at their own risk where they have not informed their employer and/or the Compensation Fund of possible grounds for a COID claim. Medical Service Providers should be aware that, under such circumstances, The Compensation Fund may not accept responsibility for the settlements of the medical expenses incurred.

i. Where a claim is repudiated by the Compensation Fund, the employee is regarded in the same position as any other member of the public in respect of payment for medical services rendered.

5. OVERVIEW OF THE COID CLAIMS PROCESS

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

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

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

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

d. Once an incident is reported to the Fund a claims number will be allocated to acknowledge receipt, but this does not imply acceptance of liability for the claim.

e. On acceptance of liability for claims in terms of the COID Act, all reasonable medical expenses, arising from the related medical condition shall be paid to medical service providers, and in accordance to approved tariffs, billing rules and procedures as published in the medical tariff gazettes of the Compensation Fund.

f. If a claim is repudiated in terms of the COID Act, medical expenses, will not be payable. The employer and the employee will be informed of this decision, and the injured employee will be liable for payment of medical costs incurred.

g. 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.

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

- All medical invoices for accepted claims must be submitted, in the prescribed manner within 36 months of the date of acceptance of liability.
- And or within 36 months from the date of service, which ever may apply.
- Medical invoices received after said time frame will be considered as late submission of invoices and may be rejected.

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

j. Submission of medical reports and invoices is permitted solely for claims where liability has been accepted by the Compensation Fund and where payment of reasonable medical expenses is authorised.

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

Submission of Medical Reports

- In terms of section 74(1)– (5) of the Compensation for Occupational Injuries and Diseases Act, 1993 (COID Act), every Medical Service Provider shall submit the prescribed medical reports when claiming from the Compensation Fund.
- The First Medical Report (W.CL 4), completed after the initial consultation, shall:
  - Confirm the clinical description of the injury or disease.
  - Detail all procedures performed; and
  - Record all referrals to other medical service providers, where applicable.
- All follow up consultations shall be recorded on a Progress Medical Report (W.CL 5). Any procedure or operation performed during the reporting period shall be clearly detailed, including all referrals, where applicable.
- A Progress Medical Report shall cover a maximum period of thirty (30) days, except where a procedure has been performed during that period, in which case an additional operation report shall be submitted.
- Where multiple procedures are performed on the same date of service, only one medical report shall be submitted in respect of that service date.
- Upon stabilisation of the injury or disease, a Final Medical Report (W.CL 5F) shall be completed and submitted
- Medical Service Providers shall attach a medical report or other appropriate medical documentation to every claim submitted to the Compensation Fund.
- Medical Service Providers shall retain copies of all submitted medical reports and shall make such records available to the Compensation Commissioner upon request.
- With effect from 1 April 2025, **ALL** medical practitioners shall submit relevant patient records together with medical invoices for services rendered. **(This includes hospitals, anaesthetists and any other practitioners that have not previously been required to do so)**

Submission of Medical Invoices

- Medical invoices shall be submitted only in respect of claims for which liability has been formally accepted by the Compensation Fund and where payment of reasonable medical expenses has been authorised.
- The submission of medical invoices without the required accompanying medical documentation shall be strictly prohibited and shall result in rejection of the invoice.
- Duplicate invoices shall not be submitted under any circumstances.
- Running accounts or statements shall not be accepted and shall be rejected at system level.

Minimum Information Requirements for Medical Invoices

Every medical invoice submitted to the Compensation Fund shall, at a minimum, include the following information:

- The allocated Compensation Fund claim number.
- The full name, surname and identity number of the employee.
- The name and Compensation Fund registration number of the employer, as reflected on the Employer's Report of Accident (W.CL 2);

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- The date of accident.
- The date(s) of service rendered.
- The Medical Service Provider's BHF practice number.
- The VAT registration number of the Medical Service Provider, where applicable.
- The applicable tariff code(s) as published in the approved tariff gazettes.
- The amount claimed per tariff code, quantity, total amount claimed including the correct sequencing of modifiers where applicable.
- A unique invoice number.

(Medical invoices that do not comply with the prescribed minimum information requirements shall be rejected and shall not be processed for payment).

VAT and Tariff Application

- Published tariff amounts shall be assessed exclusive of VAT.
- VAT shall be applied only where the Medical Service Provider is a registered VAT vendor and has supplied a valid VAT registration number on the invoice.
- Where no VAT registration number is provided, the Medical Service Provider shall be regarded as a non-VAT vendor and VAT shall not be applied.
- Notwithstanding the above, the following tariffs shall be processed as VAT inclusive:
  - Per diem tariffs applicable to private hospitals; and
  - VAT exempt tariff codes applicable to private ambulance services.

Pharmaceuticals and Referrals

- All pharmaceutical claims shall be submitted in accordance with the NAPPI file and shall be accompanied by the original prescription(s).
- Where a referral is required, the referring practitioner's referral letter shall accompany the medical invoice.

Enforcement and Non-Compliance

- The Compensation Fund shall withhold payment of any medical invoice that fails to comply with the billing and submission requirements prescribed in this document and as published in the Government Gazette.
- Noncompliance with these billing requirements shall result in rejection of claims and may result in further remedial or enforcement action by the Compensation Fund.

7. INVOICING REQUIREMENT ON MEDICAL CLAIMS FOR ICD-10 CODES

As part of improved delivery service and efficiency, The Compensation Fund has implemented ICD-10 rules that must be adhered to when submitting medical invoices. This will be rolled out in a phased approach. The first phase currently active on the system is outlined below:

ICD-10 Validations

ICD-10 validations will apply in accordance with the national ICD-10 Phase 3 and Phase 4.1 requirements and include the following:

- Valid ICD-10 codes as per the SA ICD-10 Master Industry Table
- Maximum level of specificity: ICD-10 codes must be valid at the correct 3-, 4-, or 5-character level
- Valid ICD-10 primary codes (codes not valid as primary will be rejected)
- Compliance with the dagger and asterisk rule

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- Compliance with sequelae coding rules
- Age edits for ICD-10 codes with age requirements
- Gender edits
- All injury and poisoning codes must be accompanied by external cause codes

Please ensure that you are familiar with the above requirements to avoid unnecessary claim rejections. The date and requirements for the next phase will be communicated in due course.

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 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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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	*

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FIELD	DESCRIPTION	Max Length	DATA TYPE	MANDATORY
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	
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)
060	Pharmacy
062	Maxillo-facial and Oral Surgery
066	Occupational Therapy
070	Optometry
072	Physiotherapy
075	Clinical technology (Renal Dialysis and Perfusionists)
076	Unattached operating theatres / Day clinics
077	Approved U O T U / Day clinics

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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

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.

PHYSIOTHERAPY GAZETTE 2026

PHYSIOTHERAPY TARIFF OF FEES AS FROM 1 APRIL 2026 (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	Patients hospitalised following an emergency injury on duty will not require pre-authorisation for rehabilitation services. However,the physiotherapist must submit monthly progress reports, a referral letter from the Medical Doctor and an initial treatment plan with the invoice to the Compensation Fund. All the cases are subject to case management.
004	AM and PM treatment sessions, applicable only to hospitalised patients, should be specified on the invoice and medically motivated for on **Annexure F** (Motivation for twice a day Physiotherapy) **Modifier 0004** must be quoted.
005	Out - patients will be allowed up to **20** sessions without pre-authorization.This includes return to work rehabilitation. If further treatment is necessary after a series of **20** treatment sessions for the same condition,the Physiotherapist must submit a motivation with treatment plan to the Compensation Fund for authorisation with a recent referral from the treating doctor. The Physiotherapist must submit monthly progress report to the CF. **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 08h00 and after 17h00 on weekdays, and any treatment over a weekend or public holiday. In cases where the Physiotherapist's scheduled working hours extend after 17h00 and before 08h00 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%. **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%. **c.** "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 **d.** "working hours" means 08h00 to 17h00, Monday to Friday.
007	The Physiotherapist shall submit the 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 external material used in therapy.It is recommended that when such items are used during a procedure or issued to a patient on discharge will only be reimbursed if the appropriate code is supplied on the account(72939).
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 5 kilometres** to be charged at R4,84 per km for each kilometre travelled in own car e.g. 19 km total = 19 X 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 their 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
Abbre viation	**Description**
AM	Additional Modifier
IM	Information Modifier
RM	Reduction Modifier

Modifier	**Modifier Description**
0004	IM: Information modifier indicating Am and PM physiotherapy sessions, refer to rule 004
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 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	Note that only one treatment code may be charged per treatment session.(72925/,72926,72327,72921,72923,72928,72927). The only exceptions are the one relevant evaluation code(72701 or 72702 or 72703),Treatment code72509 (extra treatment time),Visiting code(72901 or 72903), One relevant rehabilitation code and cost of material code (72939).	
Code	**Code Description**	**Rand**
1.	**Rehabilitation**	
72107	Electro/Cryo/Moist-therapy modality usage for treatment	**180.20**
72501	Rehabilitation where the pathology requires the undivided attention of the Physiotherapist. Duration: 30min. This code can only be claimed once per treatment session	**628.58**
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	**1257.38**
72505	Group Rehabilitation.Treatment of a patient with disabling pathology in an appropriate facility requiring specific equipment and supervision,without individual attention for the whole treatment session.	**424.00**
72509	Rehabilitaion, each additional full 15 mins.where the pathology requires the undivided attention of the physiotherapist.A maximum of two instances of this code may be charged per session.Tariff code 72509 can be added to 72501 and 72503.	**201.10**
72606	Physiotherapeutic group rehabilitation (<45 min),requires the undivided attention of the physiotherapist.	**795.00**
2.	**Evaluation**	
72701	Basic assessment at commencement of care,once per episode of care. 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	**362.06**
72702	Comprehensive assessment at commencement of care, once per episode of care. 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	**542.60**
72703	One complete re-assessment of a patient's condition during the course of treatment. To be used only once per single Doctor referral. This should be fully documented and a rehabilitation progress report provided to the Compensation Fund. Rule 015 applies.	**180.56**
72706	Report Writing.To be used to motivate for therapy and/or give a progress report.	**216.37**
3.	**Visiting**	
72901	Consultation: Treatment at a hospital: Relevant fee plus (to be charged only once per day).	**132.30**
72903	Consultation: Domiciliary treatments to be charged only once a day.	**240.74**

4.	Other	
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 in 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) and/or breathing ***Applies to non - ventilated patients only***	**592.75**
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* ***Applies to High Care and non - ventilated patients***	**979.39**
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.	**1243.31**
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	**870.50**

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	**1257.38**
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	**870.50**
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	**1137.02**

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
Elastic Adhesive bandage	1	195.92
Tubigrip (A & B white)	1	36.47
Self adhesive disposable electrodes (one set per employee is payable)	1	115.85
Sports		
Taping / Strapping (type & quantity must be specified)		
Elastoplast 75mm x 4.5	1	223.22
Coverol	1	172.74
Leukotape	1	223.22
Magic Grip Spray	1	168.44
Fixomull	1	190.40
Leukoban 50-75mm x 4.5m	1	96.74
Kinesiotape	1	195.92
Other		
Incontinence electrodes for pathway EMG	1	464.16
EMG flat electrodes	1	46.79
(should be medically justified)		

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	340.07
Braces		
Knee brace	1	344.00
Ankle brace	1	322.80
Cervical collar	1	188.58
Lumbar brace	1	697.25
Standard heel cups	pair	229.22
Cliniband	1	88.18
Fit band 5.5cm	1	22.36
Fit band 30cm	1	78.40
Peak flow meter	1	435.63
Peak flow meter	2	5.45
Spirometer	1	440.50

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	Y	Y

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
								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	