DEPARTMENT OF EMPLOYMENT AND LABOUR

NO. 7261 20 March 2026

SPEECH THERAPY AUDIOLOGY & ACOUSTICIANS

GAZETTE 2026

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Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

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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);

- 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.

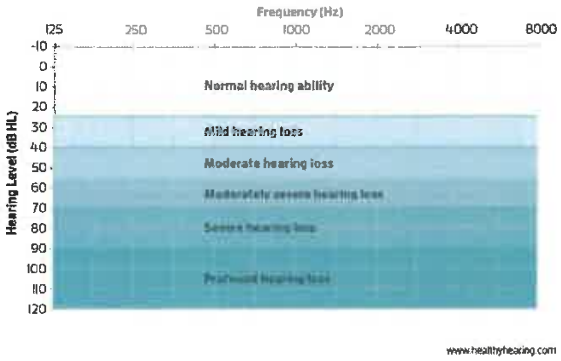
SPEECH THERAPY
&
AUDIOLOGY
GAZETTE
2026

SPEECH THERAPY, AUDIOLOGY AND ACOUSTICIANS TARIFF OF FEES AS FROM 01 APRIL 2026		
SPEECH THERAPY AND AUDIOLOGY (PRACTICE TYPE 082)		
General Rules		
Rule	**Rule Description**	
001	Pre-Authorisation is required for all Hearing Aid services	
002	A request for hearing aids must be accompanied by a referral letter from the treating medical practitioner. The referral letter must clearly indicate reasons and the relationship to the original injury or disease.	
003	Motivation from the treating medical practitioner will be required for renewal of hearing aids outside of warranty. Hearing aids still within the manufacturers warranty should be replaced or repaired at no cost to the patient or the Fund.	
004	A copy of the Referral letter shall be required from the treating doctor.	
005	Newly hospitalised patients will be allowed up to10 sessions without pre-authorisation. 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 Fund for considering further authorisation. No pre - authorisation is required for patients in ICU and High Care Units.	
006	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.	
007	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by the Fund if the appropriate code is supplied on the medical invoice.	
Tariff Codes		
Code	**Code Description**	**Rand**
1.	**Speech Therapy**	
1.1	**Speech Therapy Consultations, Assessment and Treatment**	
1020	Speech therapy consultation. Duration 5 - 15 mins	**157.98**
1021	Speech therapy consultation. Duration 16 - 30 mins	**355.64**
1022	Speech therapy consultation. Duration 31 - 45 mins	**592.02**
1.2	**Assessment & Treatment**	
1.2.1	**Speech Therapy Assessment & Treatment**	
1050	Speech Therapy assessment and treatment. Duration 5 - 15 mins	**157.98**
1051	Speech Therapy assessment and treatment. Duration 16 - 30 mins	**355.64**
1052	Speech Therapy assessment and treatment. Duration 31 - 45 mins	**592.02**
1.3	**Speech, Voice and Language Disorder**	
0007	Group therapy: per patient at rooms (Maximum of 3 patients per therapy per day) Limit of two sessions and thereafter a motivation letter is required. **Note** : Professional Group Consultations - no fee to be charged.	**231.67**
0009	Preparation of a home programme tariff code can be used once per life-time. **Note** : This category is to prepare the home programme prior to consultation with patient or care giver.	**231.67**

2.	**Audiology**	
2.1	**Audiology Consultation, Assessment & Treatment**	
1011	Audiology consultation. Duration 16 - 30 mins	**349.83**
1012	Audiology consultation. Duration 31 - 45 mins	**583.49**
1013	Audiology consultation. Duration 46 - 60 mins	**817.03**
2.2	**Audiology Evaluations**	
A.	**Peripheral Hearing Evaluation**	
1100	Pure Tone Audiogram (Air conduction) (3273 - Pure tone audiometry) (air conduction) - Doctor's file **Note:** Tariff code 3273 cannot be used with code 1110	**263.26**
1105	Pure Tone Audiogram (Bone conduction) (3274 - Pure tone audiometry) (bone conduction with masking) - Doctor's file **Note:** Tariff code cannot be used with code 1110	**210.61**
1110	Full Speech Audiogram including speech reception threshold and discrimination at two or more levels. (3277 - Speech audiometry: Item includes speech audiogram, speech reception threshold, discrimination score) - Doctor's file **Note:** Tariff code cannot be used with code 1100 and 1105	**263.26**
B.	**Middle Ear Function Evaluation**	
1200	Immittance Measurements (Impedance / Tympanometry) **Note:**Tariff code cannot be used with code 1205 and 1210	**140.41**
1205	Immittance Measurements - Impedance / Stapedial reflex (3276- Impedance audiometry) (stapedial reflex) - no code for volume, compliance etc.- Doctor's file: Limited reflex spectrum (e.g. : 1-2 frequencies) **Note:** Tariff code cannot be used with code1200 and 1210	**70.20**
1210	Immittance Measurements - Impedance / Stapedial reflex (3276 - Impedance audiometry) (stapedial reflex) - no code for volume, compliance etc.- Doctor's file Extended reflex spectrum (250-8000Hz e.g. 4-8 frequencies) **Note:** Tariff code cannot be used with code1200 and 1205	**210.61**
1220	Eustachian Tube Function Test - multiple tympanograms - bilateral **Note:** Tariff code can only be used once during a consultation or visit	**210.61**
1225	Rinné & Weber tests	**70.20**
C.	**Diagnostic Audiological Tests for Differential Diagnosis between Cochlear; Retro-cochlear; Central; Functional and/or Vestibular Pathology**	
1300	Tone Decay (for retro cochlear pathology) Tariff code can only be used for head trauma related to occupational injuries/disease. Motivation letter required	**140.41**
1305	Reflex decay (for retro cochlear pathology) Tariff code can only be used for head trauma related to occupational injuries/disease Motivation letter required	**140.41**
1310	SISI (for cochlear pathology) Tariff code can only be used for head trauma related to occupational injuries/disease	**87.75**
1315	Air conduction MCL (Most comfortable levels) & UCL (Uncomfortable levels) - for cochlear pathology and/or for purposes of selection of hearing aid technology or hearing aid programming Tariff code can only be used for head trauma related to occupational injuries/disease.	**140.41**
1320	Speech conduction MCL & UCL (for cochlear pathology) Tariff code can only be used for head trauma related to occupational injuries/disease.	**70.20**

D.	**Electro-Physiological Examinations/Auditory Evoked Potentials (AEP)**	
1515	Diagnostic Audiological Click ABR (Auditory Brainstem Evoked Response) – Bilateral Air conduction threshold determination using click stimuli	**1135.21**
1520	Diagnostic Audiological Click ABR-(Auditory Brainstem Response) – Bilateral Bone conduction threshold determination using click stimuli	**1513.57**
1534	Diagnostic Audiological Tone Burst ABR (Auditory Brainstem Response) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 4 frequencies	**2270.66**
1581	OAE (Oto-acoustic emissions) - comprehensive diagnostic evaluation	**524.80**
E.	**Balance/Vestibular Examinations and Treatment**	
1600	Spontaneous and positional nystagmus using electro-nystagmography (ENG) (3253). Cannot be used with tariff code 1605.	**1040.86**
1605	Spontaneous and positional nystagmus using Video-nystagmography (VNG). Cannot be used with tariff code 1600.	**1095.43**
1610	Eye Visualization – spontaneous and positional nystagmus – monocular	**589.59**
1615	Eye Visualization – spontaneous and positional nystagmus – binocular	**612.74**
3.	**Material**	
0300	Medication	-
0301	Material	-
F.	**Hearing Amplification / Hearing Aids**	
	Rules	
	· Product warranties should be honoured by the supplier	
	· Only out of warranty costs may be considered for funding	
	· Prices excludes professional fee for evaluation, measuring, fitting, adjusting & follow ups	
	· Each description includes the necessary accessories and hardware to make the prescribed hearing aid/accessory/replacement/repair functional as intended by the products IFU (Instruction For Use)	
	· Accessories to new hearing aids should be motivated and clinically relevant	
	· Patients are eligible for new hearing aids every 5 years. Taking the following into account: The quality of the hearing aid, how well it is maintained and wear and tear	
	· Product must be obtained, maintained and serviced in the country at an affordable cost.	
	· A limit of two (2) applies in instances where both ears (Bilateral) require hearing aid devices	
	Criteria for Hearing Aids	
	· Baseline hearing test of employee (i.e. baseline test should be done within 30 days of employment and on employees who are going to work in a noise zone for the first time or on employees working in a newly identified noise zone)	
	· A full assessment / evaluation from medical professional i.e. ENT surgeon, Audiologist.	
	· Hearing Tests: Weber Hearing test or Audiogram hearing test or Rinne hearing test or Tympanometry test or Otoacoustic Emissions Hearing loss test and/or Auditory brainstem Response Hearing loss test.	
	· More than 40 decibels is considered to be a hearing impairment for hearing aids.	
	· Less than 40 decibels needs to be motivated	
	· Confirmation of hearing loss being work related from medical professional	

HEARING LEVELS AND FREQUENCY



Information on hearing loss levels obtained from: Degrees of hearing loss and hearing loss levels (healthyhearing.com)

Tariff Codes

Code	Code Description	Rand
1800	Hearing aid evaluation - per ear	253.14
1805	Free Field Hearing Aid Evaluation : Pure tone and speech (with and without lipreading) Item cannot be used with code 1100, 1105 and 1110	219.39
1810	Insertion gain measurement, per ear	168.76
1815	Re-programming of hearing aid, per ear	168.76
1820	Technical adjustment of hearing aid / device, per ear.	101.26
1824	Hearing Aid Batteries (4)	293.88
1825	Repairs to hearing aids.	-
1830	Global charge for supply and fitting of hearing aid and follow-up Refer to Rule 001 No other tariff code can be billed with tariff code 1830	-
1831	Basic hearing aid limit	17567.53
1832	Standard hearing aid limit	17922.99
1833	Intermidiate hearing aid limit	25094.03
1834	Essential hearing aid limit	20466.87
1835	Advanced hearing aid limit	37625.64

ACOUSTICIANS GAZETTE 2026

HEARING AID ACOUSTICIANS (PRACTICE 083)		
General Rules		
Rule	**Rule Description**	
001	Pre-Authorisation is required for all hearing aid services	
002	A request for hearing aids must be accompaned by a referral letter from the treating medical practitioner.	
003	Motivation from the treating medical practitioner will be required for renewal of hearing aids.	
004	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.	
005	The fee in respect of more than one evaluation shall be the full fee for the first evaluation plus half the fee in respect of each additional evaluation, but under no circumstances may fees be charged for more than three evaluations carried out.	
Tariff Codes		
Code	**Code Description**	**Rand**
83001	First consultation (comprehensive) Units for report writing included in the tariff code	**575.85**
83003	Follow up and final consultation Units for report writing included in the tariff code	**504.03**
83021	Test - air conduction	**126.01**
83023	Test - bone conduction	**126.01**
83025	Test - speech hearing tests	**176.41**
83027	Test - free field	**161.29**
83029	Test - insertion gain (per ear)	**137.35**
83031	Test - binaural loudness balance test, per ear	**161.29**
83051	Global charge for supply and fitting of hearing aid and follow-up. Refer to Rule 001 No other tariff code can be billed with tariff code 83051	**-**
83053	Hearing Aid Evaluation, per ear (refer to General Rule 005)	**161.29**
83055	Technical adjustment or replacement of earmolds	**265.87**
83057	Repairs/service per instrument (5X services/ 5 year cycle)	**-**
83059	Tympanogram	**126.01**
83061	Reflex test (stapedial reflex)	**126.01**

ANNEXURE A: FIRST SPEECH THERAPY REPORT

1. AUTHORISATION REQUEST FORM			
Please indicate your request type with an X:			
First speech therapy report		Extension of treatment period required	
Additional treatment sessions required		Amendment to treatment codes required	
INJURED EMPLPOYEE DETAILS			
Surname:			
First Names:			
Identity Number:			
Telephone number:			
Address: Postal code:			
EMPLOYER DETAILS			
Name of Employer:			
Telephone number:			
Date of Injury / Onset of symptoms:			
REFERRING DOCTOR DETAILS			
Referring Doctor:			
Telephone Number:			
Email address:			
Referring Doctor Practice Number			
Dated referral letter stipulating reason for the referral and referring doctor stamp and signature has been included with this authorisation request:	YES	NO	
SUPPORTING DOCUMENTS ATTACHED TO AUTHORISATION REQUEST ONLY IF CLAIM NOT REGISTERED			
Please indicate attached documents with an X (only attach if necessary):			
WCL2		WCL4		ID	
INJURY / SYMPTOM DETAILS			
ICD 10 Code:			
Diagnosis:			

CURRENT PRESENTATION:

SPEECH THERAPY / AUDIOLOGY REHABILITATION PLAN	
A. SPEECH THERAPY / AUDIOLOGY REHABILITATION PLAN	
Ensure that the treatment goals are specific and measurable with outcome measurements.	
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

B. ANTICIPATED DURATION AND FREQUENCY OF TREATMENT INCLUDE DATES	
Overall expected duration of treatment intervention:	
Overall expected number of treatment sessions:	
Frequency of treatment intervention (daily; bi-daily; weekly etc):	

C. ANTICIPATED CODING FOR ABOVE TREATMENT SESSIONS			
CODE:	**QUANTITY**	**CODE:**	**QUANTITY**

MOTIVATION FOR CHANGE IN AUTHORISATION REQUEST (COMPLETE ONLY IF NOT THE FIRST SPEECH THERAPY / AUDIOLOGY REHABILITATION REPORT)

SERVICE PROVIDER DETAILS	
Name:	
Practice Number:	
Date of initial consultation:	
Date of pre-authorisation request:	
Telephone Number:	
Email address:	
Signature:	

ANNEXURE B: MONTHLY / INTERIM SPEECH THERAPY REHABILITATION REPORT

Speech Therapy / Audiology Rehabilitation Progress/Interim Monthly Report
Compensation for Occupational Injuries and Disease Act

Name and Surname of Employee:	
Identity Number:	**Address:**
	Postal Code:
Name of Employer:	
Address:	
	Postal Code:
Date of Accident:	
1. Date of First Treatment:	**Provider of First Treatment:**
2. Name of Referring Medical Practitioner:	**Date of Referral:**
3. Number of Sessions already delivered:	
4. Progress achieved (including outcome measures e.g. Swallowing ability, language ability)	
5. Did the patient undergo surgical procedures in this time? Dates and type of surgery	
6. Number of sessions required:	
7. Treatment plan for proposed treatment sessions:	
8. From what date has the employee been fit for his/her normal/ light work? (Please circle where applicable)	
I certify that I have by examination, satisfied myself that the injury(ies) are as a result of the accident.	
Signature of service provider:	**Date:**
Name:	
Practice Number:	
NB: Speech Therapy / Audiology Rehabilitation progress reports must be submitted on a monthly basis and attached to the submitted accounts	

ANNEXURE C: FINAL SPEECH THERAPY REHABILITATION REPORT

Final Report	
Compensation for Occupational Injuries and Disease Act	
Name and Surname of Employee:	**Address:**
Identity Number:	
Postal Code:	
Name of Employer:	
Address:	
Postal Code:	
Date of Accident:	
Date of First Treatment:	**Provider of First Treatment:**
Name of Referring Medical Practitioner:	**Date of Referral:**
1. Number of Sessions already delivered: From_____ To_____	
2. Progress achieved (including outcome measures e.g. Swallowing ability, language ability):	
3. Did the patient undergo surgical procedures in this time? Dates and type of surgery.	
4. From what date has the employee been fit for his/her normal work?	
5. Is the employee fully rehabilitated/has the employee obtained the highest level of function?	

6. If so, describe in detail any present permanent anatomical effect and/or impairment of function as a result of the accident (e.g. swallowing ability language ability)	
I certify that I have by examination, satisfied myself that the injury(ies) are as a result of the accident.	
Signature of service provider:	**Date:**
Name:	
Address:	**Post Code:**
Practice Number:	
NB: Speech Therapy / Audiology Rehabilitation progress reports must be submitted on a monthly basis and attached to the submitted accounts	