DEPARTMENT OF EMPLOYMENT AND LABOUR

NO. 7262 20 March 2026

RADIOGRAPHY & DIETETICS GAZETTE 2026

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Compensation Fund

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.

RADIOGRAPHY GAZETTE 2026

RADIOGRAPHY TARIFF OF FEES AS FROM 1 APRIL 2026 (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 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	**92.37**
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	**301.63**
39201	Limb per region: Shoulder, (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**424.56**
39202	Limb per region: Elbow (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**382.99**
39203	Limb per region: Knee (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**405.14**
39204	Limb per region: Foot, (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**341.54**
39205	Limb per region: Hand (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**375.77**
39206	Limb per region: Wrist (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand	**387.73**

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)	**405.14**
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)	**402.77**
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)	**358.84**
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)	**358.84**
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)	**382.99**
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)	**371.27**
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)	**371.27**
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)	**334.32**
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)	**358.84**
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)	**337.99**
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)	**358.84**
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)	**387.73**
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).	**341.54**
39005	Smith-Petersen or equivalent control, in theatre Use once per sitting	**1,005.52**
39007	Stress studies, e.g. joint	**381.32**
39009	Length studies per right and left pair of long bones Only use once for both pair of bones.	**520.37**
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.	**208.91**
39301	Cervical Spine - 2 or more views	**563.83**
39302	Per region, e.g. Sacral	**529.79**
39303	Per region, e.g. Coccygeal	**529.79**
39304	Thoracic Spine 2 Views	**422.79**
39305	Lumbar Spine - 2 or more views	**587.28**
39021	Stress studies	**75.13**
39027	Pelvis (sacro-iliac or hip joints only to be added where an extra set of views is required).	**431.57**

	Myelography	
39029	Lumbar	**322.20**
39031	Thoracic	**299.66**
39033	Cervical	**444.01**
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)	**235.24**
1.3	**Skull**	
39039	Skull studies	**454.85**
39041	Paranasal sinuses	**431.57**
39043	Facial bones and/or orbits	**463.22**
39045	Mandible	**431.57**
39047	Nasal bone	**281.80**
39049	Mastoid: Bilateral	**846.14**
1.3.1	**Teeth**	
39051	One quadrant	**235.74**
39053	Two quadrants	**298.30**
39055	Full mouth	**279.21**
39057	Rotation tomography of the teeth and jaws	**478.62**
39059	Temporo-mandibular joints: Per side	**419.50**
39061	Tomography: Per side	**227.73**
39063	Localisation of foreign body in the eye	**419.50**
39065	Ventriculography (Refer to general rule 001)	**279.58**
39067	Post-nasal studies: Lateral neck	**188.44**
39069	Maxillo-facial cephalometry	**195.06**
39071	Dacryocystography (Refer to general rule 001)	**175.51**
2.	**Alimentary Tract**	
39075	Pharynx and oesophagus (Refer to general rule 001)	**170.34**
39077	Oesophagus, stomach and duodenum (control film of abdomen included) and limited follow through (Refer to general rule 001).	**235.24**
39079	Small bowel meal (control film of abdomen included, except when part of tariff code 39081) (Refer to general rule 001).	**207.04**
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).	**352.87**
39087	Gastric/oesophageal/duodenal intubation control (Refer to general rule 001)	**155.31**
3.	**Chest**	
39105	Larynx (tomography included)	**316.90**
39107	Chest (tariff code 39167 included)	**455.59**
39109	Chest and cardiac studies (tariff code 39167 included)	**172.55**
39111	Ribs	**508.18**
39113	Sternum or sterno-clavicular joints	**595.75**

3.1	**Bronchography**	
39115	Unilateral (Refer to general rule 001)	**241.77**
39117	Bilateral. Cannot be used with tariff code 39115 (Refer to general rule 001)	**422.45**
39119	Pleurography (Refer to general rule 001)	**117.38**
39121	Laryngography (Refer to general rule 001)	**117.38**
39123	Thoracic inlet	**301.51**
4.	**Abdomen**	
39125	Control films of the abdomen (not being part of examination for barium meal, pyelogram, etc.).	**391.29**
39127	Acute abdomen or equivalent studies	**631.71**
5.	**Urinary Tract**	
39129	Control film included and bladder views before and after micturition (Refer to general rule 001)	**500.79**
39135	Cystography only or urethrography only (retrograde) (Refer to general rule 001)	**280.94**
5.1	**Cysto-Urethrography**	
39137	Retrograde (Refer to general rule 001)	**247.31**
39139	Retrograde-prograde pyelography (Refer to general rule 001)	**316.90**
39143	Tomography of renal tract: Add to item for examination performed	**143.24**
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	**1,963.00**
39157	Head, repeat examination at the same visit, after contrast, full series	**673.71**
39159	Chest	**2,269.43**
39161	Abdomen (including base of chest and/or pelvis)	**2,637.69**
39163	Multiple examinations: For an additional part, the lesser fee shall be reduced to 50%	**613.48**
39165	Limbs and other limited examinations	**613.48**

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.	**160.11**
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.	**221.08**
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.	**131.54**
39181	Setting of sterile trays Use tariff code 39181 once per sitting regardless of the number of procedures done.	**22.42**
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.	**321.34**
39192	Post-processing in catheterisation laboratory for purposes of invasive intravascular procedures.	**321.34**
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.	**321.34**
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.	**144.96**
39187	Theatre investigations with fixed installation: Add to tariff code for examination performed.	**61.95**

DIETETICS GAZETTE 2026

DIETETICS TARIFF OF FEES AS FROM 01 APRIL 2026 (PRACTICE TYPE 084)		
General Rules		
NB: Dietician services are applicable for in-hospital patients only.		
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 10 (ten) visits per claim are allowed. For more visits, motivation letter is 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**
	Individual Assessment,Counselling and/or Treatment	
84206	**Initial hospital visit**: Nutritional assessment, counselling and/or treatment. Report is required and item includes compilation of report. The relevant modifier applies.	**929.40**
84201	**Follow up hospital visit in the ward**: Nutritional assessment, counselling and/or treatment. Report is required and item includes compilation of report. The relevant modifier applies.	**199.03**
84203	**Hospital follow up visit in ICU and High Care Unit**: Nutritional assessment, counselling and/or treatment. Report is required and item includes compilation of report. The relevant modifier applies.	**597.59**
84205	**Final hospital visit**: Nutritional assessment, counselling and/or treatment. For discharge menu planning and counselling. Final report is required and item includes compilation of report. The relevant modifier applies.	**730.00**