DEPARTMENT OF EMPLOYMENT AND LABOUR

NOTICE 936 OF 2022

DIETICIAN AND RADIOGRAPHY GAZETTE 2022

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

ANNUAL INCREASE IN MEDICAL TARIFFS FOR MEDICAL SERVICES PROVIDERS.

1. I, Thembelani Waltermade Nxesi, Minister of Employment & 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 2022**.

2. Medical Tariffs increase for **2022 is 0%.**

3. The fees appearing in the Schedule are applicable in respect of all services rendered on or after **1 April 2022** and **Exclude 15% Vat.**

MR TW NXESI MP
MINISTER OF EMPLOYMENT AND LABOUR
DATE: 03/03/2022

GENERAL INFORMATION

THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

The employee is permitted to freely choose his/her own service provider e.g. doctor, pharmacy, physiotherapist, hospital, etc. and no interference with this privilege is permitted, as long as it is exercised reasonably and without prejudice to the employee or to the Compensation Fund. The only exception to this rule is in case where an employer, with the approval of the Compensation Fund, provides comprehensive medical aid facilities to his employees, i.e. including hospital, nursing and other services — section 78 of the Compensation for Occupational Injuries and Diseases Act refers.

In terms of section 42 of the Compensation for Occupational Injuries and Diseases Act, the Compensation Fund may refer an injured employee to a specialist medical practitioner designated by the Director General for a medical examination and report. Special fees are payable when this service is requested.

In terms of section 76,3(b) of the Compensation for Occupational Injuries and Diseases Act, no amount in respect of medical expenses shall be recoverable from the employee.

In the event of a change of medical practitioner attending to a case, the first doctor in attendance will, except where the case is transferred to a specialist, be regarded as the principal. **To avoid disputes regarding the payment for services rendered, medical practitioners should refrain from treating an employee already under treatment by another doctor without consulting / informing the first doctor.** As a general rule, changes of doctor are not favoured by the Compensation Fund, unless sufficient reasons exist.

According to the National Health Act no 61 of 2003, Section 5, a health care provider may not refuse a person emergency medical treatment. Such a medical service provider should not request the Compensation Fund to authorise such treatment before the claim has been submitted to and accepted by the Compensation Fund. **Pre-authorisation of treatment is not possible and no medical expense will be approved if liability for the claim has not been accepted by the Compensation Fund.**

An employee seeks medical advice at his/her own risk. If an employee represented to a medical service provider that he/she is entitled to treatment in terms of the Compensation for Occupational Injuries and Diseases Act, and yet failed to inform the Compensation Commissioner or his/her employer of any possible grounds for a claim, the Compensation Fund cannot accept responsibility for medical expenses incurred. The Compensation Commissioner could also have reasons not to accept a claim lodged against the Compensation Fund. In such circumstances the employee would be in the same position as any other member of the public regarding payment of his medical expenses.

Please note that from 1 January 2004 a certified copy of an employee's identity document will be required in order for a claim to be registered with the Compensation Fund. If a copy of the identity document is not submitted the claim will not be registered but will be returned to the employer for attachment of a certified copy of the employee's identity document. Furthermore, all supporting documentation submitted to the Compensation Fund must reflect the identity number of the employee. If the identity number is not included such documents cannot be processed but will be returned to the sender to add the ID number.

The tariff amounts published in the tariff guides to medical services rendered in terms of the Compensation for Occupational Injuries and Diseases Act do not include VAT. All invoices for services rendered will be assessed without VAT. Only if it is indicated that the service provider is registered as a VAT vendor and a VAT registration number is provided, will VAT be calculated and added to the payment, without being rounded off.

The only exception is the "per diem" tariffs for Private Hospitals that already include VAT.

Please note that there are VAT exempted codes in the private ambulance tariff structure.

CLAIMS WITH THE COMPENSATION FUND ARE PROCESSED AS FOLLOWS

1. New claims are registered by the Employers and the Compensation Fund and the **employer views the claim number allocated online.** The allocation of a claim number by the Compensation Fund, does not constitute acceptance of liability for a claim, but means that the injury on duty has been reported to and registered by the Compensation Commissioner. Enquiries regarding claim numbers should be directed to the employer and not to the Compensation Fund. The employer will be in the position to provide the claim number for the employee as well as indicate whether the claim has been accepted by the Compensation Fund.

2. If a claim is **accepted** as a COIDA claim, **reasonable medical expenses** will be paid by the Compensation Commissioner.

3. If a claim is **rejected (repudiated)**, medical expenses for services rendered will not be paid by the Compensation Commissioner. The employer and the employee will be informed of this decision and the injured employee will be liable for payment.

4. If **no decision** can be made regarding acceptance of a claim due to inadequate information, the outstanding information will be requested and upon receipt, the claim will again be adjudicated on. Depending on the outcome, the invoices from the service provider will be dealt with as set out in 2 and 3. Please note that there are claims on which a decision might never be taken due to lack of forthcoming information.

BILLING PROCEDURE

1. All service providers should be registered on the Compensation Fund claims system in order to capture medical invoices and reports.

   1.1 Medical reports should always have a clear and detailed clinical description of injury.
   1.2 A progress medical report covering a period of 30 days will be required, with an exception where a procedure was performed during that period.
   1.3 In a case where a procedure is done, an operation report is required.
   1.4 Only one medical report is required when multiple procedures are done on the same service date.
   1.5 Service providers are required to keep original documents (i.e medical reports, invoices) and these should be made available to the Compensation Commissioner on request.
   1.6 Referrals to another medical service provider should be indicated on the medical report.

2. Medical invoices should be switched to the Compensation Fund using the attached format. - Annexure D.

   2.1. Subsequent invoice must be electronically switched. It is important that all requirements for the submission of invoice, including supporting information, are submitted.
   2.2. Manual documents for medical refunds should be submitted to the nearest labour centre.

3. The status of invoices /claims can be viewed on the Compensation Fund claims system. If invoices are still outstanding after 60 days following submission, the service provider should complete an enquiry form, W.Cl 20, and submit it ONCE to the Provincial office/Labour Centre. All relevant details regarding Labour Centres are available on the website www.labour.gov.za .

4. If an invoice has been partially paid with no reason indicated on the remittance advice, an enquiry should be made with the nearest processing labour centre. The service provider should complete an enquiry form, W.Cl 20, accompanied by the original invoice with unpaid services clearly indicated, and submit it ONCE to the Provincial office/Labour Centre. All relevant details regarding Labour Centres are available on the website www.labour.gov.za .

5. Details of the employee's medical aid and the practice number of the referring practitioner must not be included in the invoice.

COMPENSATION FUND MEDICAL SERVICE PROVIDERS REGISTRATION REQUIREMENTS

Medical service providers treating COIDA patients must comply with the following requirements before submitting medical invoices to the Compensation Fund:

- Medical Service Providers must register with the Compensation Fund as a Medical Service Provider.
- Render medical treatment to in terms of COIDA Section 76 (3) (b).
- Submit Proof of registration with the Board of Healthcare Funders of South Africa.
- Submit an applicable dispensing licence on registration as a medical service provider.
- Submit SARS Vat registration number document on registration.
- A certified copy of the MSP's Identity document not older than three months.
- Proof of address not older than three months.
- Submit medical invoices with gazetted COIDA medical tariffs, relevant ICD10 codes and additional medical tariffs specified by the Fund when submitting medical invoices.
- All medical invoices must be submitted with invoice numbers to prevent system rejections. Duplicate invoices should not be submitted.
- Provide medical reports and invoices within a specified time frame on request by the Compensation Fund in terms of Section 74 (1) and (2).
- Submit the following additional information on the Medical Service Provider letterhead, Cell phone number, Business contact number, Postal address, Email address. The Fund must be notified in writing of any changes in order to effect necessary changes on the systems.
- The name of the switching house that submit invoices on behalf of the medical service provider. The Fund must be notified in writing when changing from one switching house to another.

All medical service providers will be subjected to the Compensation Fund vetting processes.

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

REQUIREMENTS FOR SWITCHING MEDICAL INVOICES WITH THE COMPENSATION FUND

The switching provider must comply with the following requirements:

1. Registration requirements as an employer with the Compensation Fund.
2. Host a secure FTP server to ensure encrypted connectivity with the Fund.
3. Submit and complete a successful test file before switching the invoices.
4 Validate medical service providers' registration with the Health Professional Council of South Africa.
5 Validate medical service providers' registration with the Board of Healthcare Funders of South Africa.
5. Ensure elimination of duplicate medical invoices before switching to the Fund.
6. Invoices submitted to the Compensation Fund must have Gazetted COIDA Tariffs that are published annually and comply with minimum requirements for submission of medical invoices and billing requirements.
7. File must be switched in a gazetted documented file format published annually with COIDA tariffs.
8. Single batch submitted must have a maximum of 100 medical invoices.
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. Medical Service Providers will be subjected to Compensation Fund vetting processes.
12. Provide any information requested by the Fund.
13. The switching provider must sign a service level agreement with the Fund.
14. Third parties must submit power of attorney.
15. Only Pharmacies should claim from the Nappi codes file.

Failure to comply with the above requirements will result in deregistration of the switching house.

MSP's PAID BY THE COMPENSATION FUND	
Discipline Code :	Discipline Description :
4	Chiropractors
9	Ambulance Services - advanced
10	Anesthetists
11	Ambulance Services - Intermediate
12	Dermatology
13	Ambulance Services - Basic
14	General Medical Practice
15	General Medical Practice
16	Obstetrics and Gynecology (work related injuries)
17	Pulmonology
18	Specialist Physician
19	Gastroenterology
20	Neurology
22	Psychiatry
23	Rediation/Medical Oncology
24	Neurosurgery
25	Nuclear Medicine
26	Ophthalmology
28	Orthopedics
30	Otorhinolaryngology
34	Physical Medicine
36	Plastic and Reconstructive Surgery
38	Diagnostic Radiology
39	Radiographers
40	Radiotherapy/Nuclear Medicine/Oncologist
42	Surgery Specialist
44	Cardio Thoracic Surgery
46	Urology
49	Sub-Acute Facilities
52	Pathology
54	General Dental Practice
55	Mental Health Institutions
56	Provincial Hospitals
57	Private Hospitals
58	Private Hospitals
59	Private Rehab Hospital (Acute)
60	Pharmacies
62	Maxillo-facial and Oral Surgery
64	Orthodontics
66	Occupational Therapy
70	Optometrists
72	Physiotherapists
75	Clinical technology (Renal Dialysis only)
76	Unattached operating theatres / Day clinics
77	Approved U O T U / Day clinics
78	Blood transfusion services
82	Speech therapy and Audiology
84	Dieticians
86	Psychologists
87	Orthotists & Prosthetists
88	Registered nurses
89	Social workers
90	Manufacturers of assisstive devices

DIETICIAN GAZETTE 2022

	DIETICIAN TARIFF OF FEES AS FROM 01 APRIL 2022	
	GENERAL RULES	
RULE	**DESCRIPTION**	
001	Referral by the principal doctor with a copy of the referral letter is required. Only one visit per day and a maximum of 7 (seven) visits per event are allowed. Motivation letter is required if more than seven visits are required.	
003	Dietary services are per individual patient.	
004	Dietary services are for in-patients only.	
	TARIFF CODES	
CODE	**DESCRIPTION**	
1.	**INDIVIDUAL ASSESSMENT, COUNSELLING AND/OR TREATMENT**	**RAND**
84201	Follow up hospital visit in the ward: Nutritional assessment, counselling and/or treatment. Duration: 11-20min. Report is required and item includes compilation of report. The relevant modifier applies.	**R161.60**
84203	Hospital follow up visit in ICU and High Care Unit: Nutritional assessment, counselling and/or treatment. Duration: 31-40min. Report is required and item includes compilation of report. The relevant modifier applies.	**R485.20**
84205	Final hospital visit: Nutritional assessment, counselling and/or treatment. Duration: 51-60min. For discharge menu planning and counselling. Final report is required and item includes compilation of report. The relevant modifier applies.	**R592.70**
84206	Initial hospital visit: Nutritional assessment, counselling and/or treatment. Duration: 61-70min. Report is required and item includes compilation of report. The relevant modifier applies.	**R 754.60**

RADIOGRAPHY GAZETTE 2022

RADIOGRAPHY TARIFF OF FEES AS FROM 1 APRIL 2022		
	GENERAL RULES	
RULE	**DESCRIPTION**	
001	AM: The specified call-out fee may be charged for any bona-fide, justifiable emergency occurring at any hour which requires the practitioner to travel to the patient. The Compensation Fund requires a motivation to accompany the claim. An emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment/ therapy and/or an operation. If the treatment is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death.	
002	Radiographer invoices will only be paid on condition that there is a referral letter from a treating practitioner.	
	MODIFIERS	
MODIFIER	**DESCRIPTION**	**RAND**
0001	Emergency fee	**75.80**
0084	Film Cost : The cost of film is included in the comprehensive procedure codes and is not billed separately	
	TARIFF CODES	
CODE	**DESCRIPTION**	**RAND**
1.	**SKELETON**	
1.1	**LIMBS**	
39001	Finger, toe	**244.90**
39003	Limb per region, e.g. shoulder, elbow, knee, foot, hand, wrist or ankle (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand) Item can be used multiple times for different anatomical sites of the limb/s	**111.76**
39005	Smith-Petersen or equivalent control, in theatre Use once per sitting	**816.40**
39007	Stress studies, e.g. joint	**309.60**
39009	Length studies per right and left pair of long bones Only use once for both pair of bones	**422.50**
39015	Arthrography per joint	**239.70**
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	**169.62**
39021	Stress studies	**61.00**
39027	Pelvis (sacro-iliac or hip joints only to be added where an extra set of views is required)	**350.40**
1.2.1	**MYELOGRAPHY**	
39029	Lumbar	**261.60**
39031	Thoracic	**243.30**
39033	Cervical	**360.50**
39035	Multiple (lumbar, thoracic, cervical): Same fee as for first segment (no additional introduction of contrast medium)	-
39037	Discography	**191.00**

1.3	**SKULL**	
39039	Skull studies	**369.30**
39041	Paranasal sinuses	**350.40**
39043	Facial bones and/or orbits	**376.10**
39045	Mandible	**350.40**
39047	Nasal bone	**228.80**
39049	Mastoid: Bilateral	**687.00**
1.3.1	**TEETH**	
39051	One quadrant	**191.40**
39053	Two quadrants	**242.20**
39055	Full mouth	**226.70**
39057	Rotation tomography of the teeth and jaws	**388.60**
39059	Temporo-mandibular joints: Per side	**340.60**
39061	Tomography: Per side	**184.90**
39063	Localisation of foreign body in the eye	**340.60**
39065	Ventriculography	**227.00**
39067	Post-nasal studies: Lateral neck	**153.00**
2.	**ALIMENTARY TRACT**	
39075	Pharynx and oesophagus	**138.30**
39077	Oesophagus, stomach and duodenum (control film of abdomen included) and limited follow through	**191.00**
39079	Small bowel meal (control film of abdomen included, except when part of item 081)	**168.10**
39081	Barium meal and dedicated gastro-intestinal tract follow through (including control film of the abdomen, oesophagus, duodenum, small bowel and colon)	**286.50**
39087	Gastric/oesophageal/duodenal intubation control	**126.10**
3.	**CHEST**	
39105	Larynx (tomography included)	**257.30**
39107	Chest (item 167 included)	**369.90**
39109	Chest and cardiac studies (item 167 included)	**140.10**
39111	Ribs	**412.60**
39113	Sternum or sterno-clavicular joints	**483.70**
3.1	**BRONCHOGRAPHY**	
39115	Unilateral	**196.30**
39117	Bilateral Cannot be used with item 39115	**343.00**
39119	Pleurography	**95.30**
39121	Laryngography	**95.30**
39123	Thoracic inlet	**244.80**
4.	**ABDOMEN**	
39125	Control films of the abdomen (not being part of examination for barium meal, pyelogram, etc.)	**317.70**
39127	Acute abdomen or equivalent studies	**512.90**
5.	**URINARY TRACT**	
39129	Control film included and bladder views before and after micturition	**406.60**
39135	Cystography only or urethrography only (retrograde) Refer to general rule 001	**228.10**
5.1	**CYSTO-URETHROGRAPHY**	
39137	Retrograde	**200.80**
39139	Retrograde-prograde pyelography	**257.30**
39143	Tomography of renal tract: Add to item for examination	**116.30**

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**	
39155	Head, single examination, full series	**1 593.80**
39157	Head, repeat examination at the same visit, after contrast, full series	**547.00**
39159	Chest	**1 842.60**
39161	Abdomen (including base of chest and/or pelvis)	**2 141.60**
39163	Multiple examinations: For an additional part, the lesser fee shall be reduced to	**498.10**
39165	Limbs and other limited examinations	**498.10**
	MODIFIER GOVERNING THIS SPECIFIC SECTION OF THE TARIFFS	
8.	**MISCELLANEOUS**	
39167	Fluoroscopy: Per half hour: Add to item for examination performed (not applicable to items 107 and 109) Refer to general rule 001 Reflect time on the claim or invoice	**130.00**
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.	**179.50**
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	**106.80**
39181	Setting of sterile trays Use item 39181 once per sitting regardless of the number of procedures done.	**18.20**
	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.	**260.90**
39192	Post-processing in catheterisation laboratory for purposes of invasive intravascular procedures	**260.90**
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.	**260.90**
9.	**PORTABLE UNIT EXAMINATIONS**	
39185	Where portable x-ray unit is used in the hospital or theatre: Add to item for examination performed	**117.70**
39187	Theatre investigations with fixed installation : Add to item for examination performed	**50.30**

COMPEASY ELECTRONIC INVOICING FILE LAYOUT

Field	Description	Max length	Data Type
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	Member surname	20	Alpha
7	Member initials	4	Alpha
8	Member first name	20	Alpha
9	BHF Practice number	15	Alpha
10	Switch ID	3	Numeric
11	Patient reference number (account number)	10	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

Field	Description	Max length	Data Type
19	Service fee	1	Numeric
20	Modifier 1	5	Alpha
21	Modifier 2	5	Alpha
22	Modifier 3	5	Alpha
23	Modifier 4	5	Alpha
24	Invoice Number	10	Alpha
25	Practice name	40	Alpha
26	Referring doctor's BHF practice number	15	Alpha
27	Medicine code (NAPPI CODE)	15	Alpha
28	Doctor practice number -sReferredTo	30	Numeric
29	Date of birth / ID number	13	Numeric
30	Service Switch transaction number – batch number	20	Alpha

31	Hospital indicator	1	Alpha
32	Authorisation number	21	Alpha
33	Resubmission flag	5	Alpha
34	Diagnostic codes	64	Alpha
35	Treating Doctor BHF practice number	9	Alpha
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

Field	Description	Max length	Data Type
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