DEPARTMENT OF LABOUR

NOTICE 212 OF 2018

PROPOSED ANNUAL IN MEDICAL SERVICE PROVIDERS, FOR 2018/2019 FINANCIAL YEAR

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

ANNUAL INCREASE IN MEDICAL TARIFFS FOR MEDICAL SERVICE PROVIDERS.

1. I, Mildred Nelisiwe Oliphant, Minister of 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), I 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 2018**.

2. Medical Tariffs increase for **2018 is 6.4%** with exception of assistive medical devices.

3. The current **2017/ 2018** rate for assistive medical devices will prevail for 2018/2019 financial year.

4. The fees appearing in the Schedule are applicable in respect of services rendered on or after **1 April 2018** and **Exclude Vat.**

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MN OLIPHANT, MP

MINISTER OF LABOUR

DATE: 10/04/2018.....

GENERAL INFORMATION / *ALGEMENE INLIGTING*

THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

The employee is permitted to freely choose his 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 of his choice for a medical examination and report. Special fees are payable when this service is requested.

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 own risk. If an employee represented to a medical service provider that he 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 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 can not 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 accounts 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.

DIE WERKNEMER EN DIE MEDIESE DIENSVERSKAFFER

Die werknemer het 'n vrye keuse van diensverskaffer bv. dokter, apteek, fisioterapeut, hospitaal ens. *en geen inmenging met hierdie voorreg word toegelaat nie, solank dit redelik en sonder benadeling van die werknemer self of die Vergoedingsfonds uitgeoefen word. Die enigste uitsondering op hierdie reël is in geval waar die werkgewer met die goedkeuring van die Vergoedingskommissaris omvattende geneeskundige dienste aan sy werknemers voorsien, d.i. insluitende hospitaal-, verplegings- en ander dienste — artikel 78 van die Wet op Vergoeding vir Beroepsbeserings en Siektes verwys.*

Kragtens die bepalings van artikel 42 van die Wet op Vergoeding vir Beroepsbeserings en Siektes mag die Vergoedingskommissaris 'n beseerde werknemer na 'n ander geneesheer deur homself aangewys verwys vir 'n mediese ondersoek en verslag. Spesiale fooie is betaalbaar vir hierdie diens wat feitlik uitsluitlik deur spesialiste gelewer word.

In die geval van 'n verandering in geneesheer wat 'n werknemer behandel, sal die eerste geneesheer wat behandeling toegedien het, behalwe waar die werknemer na 'n spesialis verwys is, as die lasgewer beskou word. ***Ten einde geskille rakende die betaling vir dienste gelewer te voorkom, moet geneeshere hul daarvan weerhou om 'n werknemer wat reeds onder behandeling is te behandel sonder om die eerste geneesheer in te lig****. Oor die algemeen word verandering van geneesheer, tensy voldoende redes daarvoor bestaan, nie aangemoedig nie.*

Volgens die Nasionale Gesondheidswet no 61 van 2003 Afdeling 5, mag 'n gesondheidswerker of diensverskaffer nie weier om noodbehandeling te verskaf nie. Die Vergoedingskommissaris kan egter nie sulke behandeling goedkeur alvorens aanspreeklikheid vir die eis kragtens die Wet op Vergoeding vir Beroepsbeserings en Siektes aanvaar is nie. ***Vooraf goedkeuring vir behandeling is nie moontlik nie en geen mediese onkoste sal betaal word as die eis nie deur die Vergoedingsfonds aanvaar word nie.***

Dit moet in gedagte gehou word dat 'n werknemer geneeskundige behandeling op sy eie risiko aanvra. As 'n werknemer dus aan 'n geneesheer voorgee dat hy geregtig is op behandeling in terme van die Wet op Vergoeding vir Beroepsbeserings en Siektes en tog versuim om die Vergoedingskommissaris of sy werkgewer in te lig oor enige moontlike gronde vir 'n eis, kan die Vergoedingsfonds geen aanspreeklikheid aanvaar vir geneeskundige onkoste wat aangegaan is nie. Die

Vergoedingskommissaris kan ook rede hê om 'n eis teen die Vergoedingsfonds nie te aanvaar nie. Onder sulke omstandighede sou die werknemer in dieselfde posisie verkeer as enige lid van die publiek wat betaling van sy geneeskundige onkoste betref.

Neem asseblief kennis dat 'n ***gesertifiseerde afskrif van die werknemer se identiteitsdokument benodig word vanaf 1 Januarie 2004*** *om 'n eis by die Vergoedingsfonds aan te meld. Indien 'n afskrif van die identiteitsdokument nie aangeheg is nie, sal die eis nie geregistreer word nie en die dokumente sal teruggestuur word aan die werkgewer vir die aanheg van die ID dokument. Alle ander dokumentasie wat aan die kantoor gestuur word moet ook die identiteitsnommer aandui. Indien nie aangedui nie, sal die dokumentasie nie verwerk word nie, maar teruggestuur word vir die aanbring van die identiteitsnommer.*

Die bedrae gepubliseer in die handleiding tot tariewe vir dienste gelewer in terme van die Wet op Vergoeding vir Beroepsbeserings en Siektes, sluit BTW uit. Die rekenings vir dienste gelewer word aangeslaan en bereken sonder BTW.

Indien BTW van toepassing is en 'n BTW registrasienommer voorsien is, word BTW bereken en by die betalingsbedrag gevoeg sonder om afgerond te word.

Die enigste uitsondering is die "per diem" tarief vir Privaat Hospitale, wat BTW insluit.

Neem asseblief kennis dat daar tariewe in die kodestruktuur vir privaat ambulanse is waarop BTW nie betaalbaar is nie.

CLAIMS WITH THE COMPENSATION FUND ARE PROCESSED AS FOLLOWS •
EISE TEEN DIE VERGOEDINGSFONDS WORD AS VOLG GEHANTEER

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 • *Nuwe eise word geregistreer deur die werkgewer en die Vergoedingsfonds en die* ***werkgewer. Die eisnommer is opdie web beskikbaar****. Navrae aangaande eisnommers moet aan die werkgewer gerig word en nie aan die Vergoedingskommissaris nie. Die werkgewer kan die eisnommer verskaf en ook aandui of die Vergoedingsfonds die eis aanvaar het of nie*

2. If a claim is **accepted** as a COIDA claim, **reasonable medical expenses** will be paid by the Compensation Commissioner • *As 'n eis deur die Vergoedingsfonds* ***aanvaar*** *is, sal* ***redelike mediese koste*** *betaal word deur die Vergoedingsfonds.*

3. If a claim is **rejected (repudiated)**, accounts 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. • *As 'n eis deur die Vergoedingsfonds afgekeur* ***(gerepudieer)*** *word, word rekenings vir dienste gelewer nie deur die Vergoedingsfonds betaal nie. Die betrokke partye insluitend die diensverskaffers word in kennis gestel van die besluit. Die beseerde werknemer is dan aanspreeklik vir betaling van die rekenings.*

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 accounts 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 • *Indien* ***geen besluit*** *oor die aanvaarding van 'n eis weens 'n gebrek aan inligting geneem kan word nie, sal die uitstaande inligting aangevra word. Met ontvangs van sulke inligting sal die eis heroorweeg word. Afhangende van die uitslag, sal die rekening gehanteer word soos uiteengeset in punte 1 en 2. Ongelukkig bestaan daar eise waaroor 'n besluit nooit geneem kan word nie aangesien die uitstaande inligting nooit verskaf word nie.*

BILLING PROCEDURE • *EISE PROSEDURE*

1. All service providers should be registered on the Compensation Fund electronic claims system (Umehluko) in order to capture medical reports. • *Alle mediese intansies moet geregistreer wees op die Vergoedings Kommissaris se nuwe elektroniese stelsel (Umehluko), om mediese verslae te dokumenteer.*

   1.1 Medical reports should always have a clear and detailed clinical description of injury
   1.2 In a case where a procedure is done, an Operation report is required
   1.3 Only one medical report is required when multiple procedures are done on the same service date
   1.4 A medical report is required for every invoice submitted covering every date of service.
   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 If there's any referrals to another medical service provider, it should be indicated on the medical report.

2. Medical invoices should be switched to the Compensation Fund using the attached format. - Annexure D. • *Mediese rekeninge moet oorgeskuif word na die Vergoedings Kommissaris, deur die aangehegte formule te gebruik. 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 • *Daarop volgende rekeninge moet elektronies ingedien word. Dit is belangrik dat al die voorskrifte vir die indiening van rekeninge nagekom word, insluitend die voorsiening van stawende dokumentasie.*

3. The status of invoices /claims can be viewed on the Compensation Fund electronic 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 • *Die status van rekeninge kan besigtig word op die Vergoedings Kommissaris se elektroniese stelsel. Indien rekenings nog uitstaande is na 60 dae vanaf indiening en ontvangs erkenning deur die Vergoedings Kommissaris, moet die diensverskaffer 'n navraag vorm, W.Cl 20 voltooi en EENMALIG indien by die Arbeidsentrum. Alle inligting oor Arbeidsentrums is beskikbaar op die webblad 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 labour centre. 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 • ***Indien 'n rekening gedeeltelik betaal is met geen rede voorsien op die betaaladvies nie, kan 'n navraag by die Arbeidsentrum gedoen word. Die diensverskaffer moet 'n navraag vorm, W.Cl 20 voltooi en EENMALIG indien by die Arbeidsentrum. Alle inligting oor Arbeidsentrums is beskikbaar op die webblad 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. • *Inligting van die werknemer se mediese fonds en praktyk nommer van die verwysende dokter moet nie ingesluit wees op die rekeninge nie.*

6. Service providers **should not generate the following** • *Diensverskaffers **moet nie die volgende lewer nie**:*

    a. **Multiple invoices** for services rendered on the **same date** i.e. one invoice for medication and a second invoices for other services • ***Meer as een rekening** vir dienste gelewer op **dieselfde datum**, bv. medikasie op een rekening en 'n ander dienste op 'n tweede rekening.*

*** Examples of the new forms (W.Cl 4 / W.Cl 5 / W.Cl 5F) are available on the website www.labour.gov.za •**
*** *Voorbeelde van die nuwe vorms* (W.Cl 4 / W.Cl 5 / W.Cl 5F) *is beskikbaar op die webblad www.labour.gov.za***

MINIMUM REQUIREMENTS FOR ACCOUNTS RENDERED • MINIMUM VEREISTES VIR REKENINGE GELEWER

Minimum information to be indicated on accounts submitted to the Compensation Fund • ***Minimum besonderhede*** *wat aangedui moet word op rekeninge gelewer aan die Vergoedingsfonds*

- Name of employee and ID number • *Naam van werknemer en ID nommer*
- Name of employer and registration number if available • *Naam van werkgewer en registrasienommer indien beskikbaar*
- Compensation Fund claim number • *Vergoedingsfonds eisnommer*
- DATE OF ACCIDENT (not only the service date) • *DATUM VAN BESERING (nie slegs die diensdatum nie)*
- Service provider's reference and **invoice number** • *Diensverskaffer se verwysing of* ***faktuur nommer***
- The practice number (changes of address should be reported to BHF) • *Die praktyknommer (adresveranderings moet by BHF aangemeld word)*
- VAT registration number (VAT will not be paid if a VAT registration number is not supplied on the account) • *BTW registrasienommer (BTW sal nie betaal word as die BTW registrasienommer nie voorsien word nie)*
- Date of service (the actual service date must be indicated: the invoice date is not acceptable) • *Diensdatum (die werklike diensdatum moet aangedui word: die datum van lewering van die rekening is nie aanvaarbaar nie)*
- Item codes according to the officially published tariff guides • *Item kodes soos aangedui in die amptelik gepubliseerde handleidings tot tariewe*
- Amount claimed per item code and total of account • *Bedrag geëis per itemkode en totaal van rekening.*
- It is important that all requirements for the submission of accounts are met, including supporting information, e.g • *Dit is belangrik dat alle voorskrifte vir die indien van rekeninge insluitend dokumentasie nagekom word bv.*
    - All pharmacy or medication accounts must be accompanied by the original scripts • *Alle apteekrekenings vir medikasie moet vergesel word van die oorspronklike voorskrifte*
    - The referral notes from the treating practitioner must accompany all other medical service providers' accounts. • *Die verwysingsbriewe van die behandelende geneesheer moet rekeninge van ander mediese diensverskaffers vergesel*

TARIFF OF FEES IN RESPECT OF PHYSIOTHERAPY SERVICES

FROM 1 APRIL 2018

001. Unless timely steps are taken to cancel an appointment, the relevant fee may be charged to the employee. Each case shall be considered on merit and if the circumstances warrant, no fee shall be charged.

002. In exceptional cases where the tariff fee is disproportionately low in relation to the actual services rendered by a physiotherapist, a higher fee may be negotiated. Conversely, if the fee is disproportionately high in relation to the actual services rendered, a lower fee than that in the tariff should be charged.

003.

Newly hospitalised patients will be allowed up 20 sessions without pre-authorisation. After a series of 20 treatment sessions in hospital, the treating medical practitioner must submit motivation with a treatment plan to the Compensation Fund for authorisation.

004. AM and PM treatment sessions, applicable only to hospitalised patients, should be specified and medically motivated for on the progress rehabilitation report.

005. In cases of out-patients, all treatment sessions will need pre-authorisation. The physiotherapist must submit a referral with motivation from the treating doctor and a treatment plan.The first consultation can be done before pre-authorisation to allow the physiotherapist to provide a treatment plan to the Fund for pre-authorisation.

006. "After hour treatment" shall mean all physiotherapy performed where emergency treatment and /or essential continuation of care is required after working hours, before 07:00 and after 17:00 on weekdays, and any treatment over a weekend or public holiday . In cases where the physiotherapist's scheduled working hours extend after 17:00 and before 07:00 during the week or weekend, the above rule shall not apply and the treatment fee shall be that of the normal listed tariff. The fee for all treatment under this rule shall be the total fee for the treatment plus 50 per cent. Modifier 006 must then be quoted after the appropriate tariff code to indicate that this rule is applicable.

For the purpose of this rule:
Emergency treatment and/or essential continuation of care refers to a physiotherapy procedure , where failure to provide the procedure would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the patient's life in serious jeopardy.

007. The physiotherapist shall submit his / her account for treatment to the employer of the employee concerned.

008. When an employee is referred for physiotherapy treatment after a surgical procedure, a new treatment plan needs to be provided to the Fund.

011. Cost of material does not include consumables (e.g. ultrasound gel, massage oil, gloves, alcohol swabs, facial tissues, paper towels and etc.)

012. An account for services rendered will be assessed and added without VAT. VAT is then calculated and added to the final payment amount.

013. Where a physiotherapist is called out from residence or rooms to an employee's home or hospital, travelling fees to be charged for travelling will be R 3.30 per kilometer from the 1st kilometer. If more than one employee is attended to during the course of a trip, the full travelling expenses must be divided pro rata between the relevant employees(the physiotherapist will claim for one trip). A physiotherapist is not entitled to charge any travelling expenses or travelling time to his / her rooms.

014. Physiotherapy services rendered in a hospital or nursing facility.

015. The services of a physiotherapist shall be available only on referral from the treating medical practitioner. Where a physiotherapist's letterhead is used as a referral letter, it must bear the medical practitioner's signature, date and stamp. The referral letter for any physiotherapy treatment provided should be submitted to the Compensation Commissioner with the account for such services.

Physiotherapist, Occupational Therapists and Chiropractors cannot give the treatment concurrently and the treatment must not overlap.

MODIFIERS GOVERNING THE TARIFF

0001 To be quoted after appropriate treatment codes when rule 001 is applicable.

0006 Add 50% of the total fee for the treatment.

0013 R3.30 per km for each kilometre

0014. Treatment in a nursing facility.

PHYSIOTHERAPY TARIFF OF FEES AS FROM 1 APRIL 2018

Please note that only one treatment code may be charged per treatment. The only exceptions are one relevant evaluation code (**72701** or **72702** or **72703**, treatment code **72509** (extra treatment time), one visiting code (**72901** or **72903**) and cost of material code(**72939**)

Code	Service type	Service description	2018 Tariffs
72701	Evaluation level 1 (to be fully documented)	Applies to simple evaluation **once** at first visit only. It should not be used for each condition. A treatment plan / rehabilitation progress report must be submitted at the initiation of treatment.	**248.06**
72702	Complex evaluation (to be fully documented)	Complex evaluation **once** at first visit only. Applies to complex evaluation once at first visit only. Applies to complex injuries only.It should not be used for each condition. A treatment plan / rehabilitation progress report describing what makes the evaluation complex, must be submitted at the initiation of treatment.	**371.76**
72703	Re-assessment	Complete re-assessment or therapeutic counselling or one physical pefomance test during the course of treatment. This should be fully documented and a rehabilitation progress report provided to th CF.	**123.71**
72901	Treatment at nursing home	Relevant fee plus (to be charged only once per day and not with every hospital visit)	**90.65**
72305	Very Simple treatment	Very simple treatment for one condition/injury of one area requiring only one treatment technique.	**90.65**
72509	Extra treatment time	Should be medically motivated for e.g. complicated condition. This code can only be claimed once per treatment session.	**137.78**
72903	Domiciliary treatments	Apply only when medically motivated: relevant fee plus.	**164.94**
72925	Level 1 chest pathology	Applies to simple chest conditions / injuries. Multiple treatment techniques to be used.	**406.12**
72926	Level 2 chest pathology	Applies only to complex chest conditions / injuries that require undivided attention of the physiotherapist. Multiple treatment techniques to be used.	**671.02**
72921	Simple spinal treatment	Applies to simple spinal injuries / conditions. Multiple treatment techniques to be used.	**596.41**
72923	Complex spinal treatment	Applies to complex spinal injuries/conditions. Multiple treatment techniques to be used. Rehabilitation reports must clearly indicate the reasons for choosing complex as apposed to simple.	**861.48**
72928	Simple soft tissue / peripheral joint injuries or other general treatment	Applies to simple soft tissue / peripheral joint injuries / conditions.Multiple treatment techniques to be used.	**596.41**

72927	Complex soft tissue / peripheral joint injuries or other general treatment	Applies to complex soft tissue/peripheral joint injuries/conditions. Multiple treatment techniques to be used. Rehabilitation reports must clearly indicate the reasons for choosing complex as opposed to simple.	**779.01**
72501	Rehabilitation	Rehabilitation first 30 minutes, where the pathology requires the undivided attention of the physiotherapist	**430.67**
72503	Rehabilitation centralnervous system	Also includes spinal rehabilitation (cannot be charged for bed exercises / passive movements only)	**861.48**
72939	Cost of material	Single items below R 1733.90 (VAT excl)may be charged for at cost price plus 20% storage and handling fees. The invoice must be attached to the account.	
		Cost of materials does not cover consumables	
		See the attached **Annexure A** for consumables and **Annexure B** for equipment and or appliances that are considered reasonable to be used with code 72939	

ANNEXURE A

LIST OF CONSUMABLES

To be used with code 72939

Service providers may add on 20% for storage and handling

NAME OF PRODUCT	UNIT	APPROX UNIT PRICE(excl VAT)
Tubigrip (A & B white)	1	**166.25**
Self adhesive disposable electrodes (one set per employee is payable)	1	**66.44**
Sports		
Taping / Strapping (type & quantity must be specified)		
Elastoplast 75mm x 4.5	1	**142.52**
Coverol	1	**106.03**
Leukotape	1	**142.52**
Magic Grip Spray	1	**102.93**
Fixomull	1	**118.80**
Leukoban 50-75mm x 4.5m	1	**55.48**
Other		
Incontinence electrodes for pathway EMG	1	**316.62**
EMG flat electrodes	1	**26.84**
(should be medically justified)		

ANNEXURE B

List of equipment / appliances to be used with code 72939
Service providers may add on 20% for storage and handling
Equipment not payable if the same were already supplied by an Prosthetist to the same employee

NAME OF PRODUCT	UNIT	APPROX UNIT PRICE(excl VAT)
Hot / cold packs	1	63.32
Braces		
Cervical collar	1	63.32
Lumbar brace	1	372.08
Standard heel cups	pair	95.07
Cliniband	1	50.57
Fit band 5.5cm	1	128.28
Fit band 30cm	1	449.64
Peak flow meter	1	296.01
Peak flow meter	2	3.12

Claim number: ----------

Physiotherapy Rehabilitation progress report
Compensation for Occupational injuries and disease act, 1993
(Act No.130 0f 1993)

PART 1 - INITIAL EVALUATION AND PLAN

Submit with first account

Names and Surname of Employee _____
Identity Number _____ Address _____
_____
_____ Postal Code _____

Name of Employer _____
Address _____
_____
_____ Postal Code _____
Date of Accident _____ Date of referral _____
Name of referring medical practitioner _____

Name of Physiotherapist _____
Practice Number _____
Physiotherapy Account number _____

1. Date of first treatment _____
2. Initial clinical presentation _____
_____
_____
3. Describe patient's symptoms and functional status _____
_____
_____
_____
4. Are there any complicating factors that may prolong rehab or delay recovery (specify)?
_____
_____
_____
5. Overall goal of treatment _____
_____
_____
6. Treatment Plan for proposed treatment session _____
_____
_____

Signature of Physiotherapist _____ Date _____

Claim number_____

Physiotherapy Rehabilitation progress report
Compensation for Occupational injuries and disease act, 1993
(Act No.130 0f 1993)

PART 2 - TREATMENT AND PROGRESS (Monthly)

Submit on a monthly basis attached to the submitted accounts

Names and Surname of Employee _____
Identity Number _____Address_____

_____

_____Postal Code_____

Name of Employer_____
Address_____

_____

_____Postal Code _____
Date of Accident _____ Date of referral_____
Name of referring medical practitioner_____

Name of Physiotherapist_____
Practice Number_____
Physiotherapy Account number_____

1. Number of Sessions (dates) already delivered? _____From_____To_____
2. Progress achieved_____

_____

_____

_____

3. Did the patient undergo surgical procedures during this treatment period? _____
Dates of surgical procedures_____

_____

4. Number of sessions (dates) still required_____
5. Treatment plan for proposed treatment sessions_____

_____

_____

_____

Signature of Physiotherapist_____Date_____

Claim number_____

Physiotherapy Rehabilitation progress report
Compensation for Occupational injuries and disease act, 1993
(Act No.130 0f 1993)

PART 3 - FINAL PROGRESS REPORT

Submit with final account

Names and Surname of Employee _____
Identity Number _____Address_____

_____

_____Postal Code_____

Name of Employer_____
Address_____

_____

_____Postal Code _____
Date of Accident _____ Date of referral_____
Name of referring medical practitioner_____

Name of Physiotherapist_____
Practice Number_____
Physiotherapy Account numbers_____

Date of final treatment_____ Number of treatment Dates_____

Progress achieved_____

_____

From what date has the employee been fit for his/her normal work? _____

_____

Is the employee fully rehabilitated/has the employee obtained the highest level of function?

_____

If not, describe in detail any present permanent anatomical defect and/or impairment of function as a result of the accident (R.O.M., if applicable, must be indicated in degrees at each specific joint) _____

_____

_____

_____

Signature of the Physiotherapist_____Date_____