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DEPARTMENT OF EMPLOYMENT AND LABOUR

NOTICE 940 OF 2022

SPEECH THERAPY AUDIOLOGY AND OPTOMETRY GAZETTE 2022

NOTICE

employment & labour
Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

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DEPARTMENT OF EMPLOYMENT & LABOUR

NOTICE: **DATE:**

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: 31/03/2022

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.

5.1 If a medical service provider claims an amount less than the published tariff amount for a code, the Compensation Fund will only pay the claimed amount and the short fall will not be paid.

6. Service providers should not generate the following:

6.1 Multiple invoices for services rendered on the same date i.e one invoice for medication and second invoices for other services.

6.2 Accumulative invoices – submit a separate invoice for every month.

*** Examples of the forms (W.Cl 4 / W.Cl 5 / W.Cl 5F) are available on the website www.labour.gov.za •**

MINIMUM REQUIREMENTS FOR INVOICES RENDERED

Minimum information to be indicated on invoices submitted to the Compensation Fund

- Compensation Fund claim number
- Name of employee and ID number
- Name of employer and registration number if available
- DATE OF ACCIDENT (not only the service date)
- Service provider's **invoice number**
- The practice number (changes of address should be reported to BHF)
- VAT registration number (VAT will not be paid if a VAT registration number is not supplied on the invoice)
- Date of service (the actual service date must be indicated: the invoice date is not acceptable)
- Item codes according to the officially published tariff guides
- Amount claimed per item code and total of the invoice
- It is important that all requirements for the submission of invoices are met, including supporting information, e.g:
    - All pharmacy or medication invoices must be accompanied by the original scripts
    - The referral letter from the treating practitioner must accompany the medical service providers' 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

SPEECH THERAPIST GAZETTE 2022

	SPEECH THERAPY TARIFF OF FEES AS FROM 1 APRIL 2022	
	GENERAL RULES	
RULE	**DESCRIPTION**	
	RULES GOVERNING SPEECH THERAPY	
001	Referral by the principal doctor with a copy of the referral letter for speech therapy services is required.	
003	Newly hospitalised patients will be allowed up 10 sessions without pre-authorisation. If further treatment is necessary after a series of 10 treatment sessions for the same condition, the treating medical practitioner must submit a motivation with treatment plan to the Compensation Fund for considering further authorisation. No pre- authorisation is required for critically ill patients in ICU and High Care Units.	
004	Unless timely steps are taken to cancel an appointment, the relevant fee may be charged to the employee.	

TARIFF CODES

Code	**Description**	
1.	**Speech Therapy Consultations, Assessment and Treatment**	
1020	First speech therapy consultation including assessment and treatment, and writing of a report. Duration 46 - 60 minutes. Units for **assessment, treatment and report writing** included in the item. Use code once only.	1 692.90
1021	Follow up speech therapy consultation, speech therapy assessment and treatment, including writing of a report. Duration 16 - 30 minutes. Units for **assessment, treatment and repo**rt writing included in the item.	940.50
1022	Final speech therapy consultation, speech therapy assessment and treatment, and writing of a report. Duration 31 - 45 minutes Units for **assessment, treatment and report writing** included in the item.	1 316.70
2.	**Speech, Voice and Language Disorder**	
0007	Group therapy: per patient at rooms (Maximum of 3 patients per therapy per day). Code cannot be used for patients admitted to any hospital. Limit of two sessions and thereafter a motivation letter is required. Note: Professional Group Consultations - no fee to be charged.	188.10
0009	Preparation of a home programme Item can be used once per life-time. Note: This category is to prepare the home programme prior to consultation with patient or care giver.	188.10

AUDIOLOGIST GAZETTE 2022

AUDIOLOGY TARIFFS

TARIFF CODES		
Code	**Description**	
1011	First audiology consultation including assessment and treatment, and writing of a report	462.77
1012	Follow-up audiology consultation including assessment and treatment, and writing of a report	277.66
1013	Final audiology consultation including assessment and treatment, and writing of a report	277.66
1100	Air conduction,pure tone audiogram	408.90
1830	Hearing Aids	

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 eg. 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: Sppech 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 eg. 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	

OPTOMETRIST GAZETTE 2022

OPTOMETRIST TARIFF OF FEES AS FROM 1 APRIL 2022		
PROCEDURE CODE	**DESCRIPTION**	**RAND**
11001	Optometric Examination **Note:** Relevant for replacement of spectacles or contact lenses.	561,00
11046	Ocular Pathology Examination **Note:** When IOD has caused ocular injury.	631,00
11061	Low Vision Examination **Note:** When IOD has caused deterioration of vision to sub-standard levels, or following IOD incident of low-vision patient.	778,00
11356	Gonioscopy **Rule:** can be billed in addition to 11001 or 11046 when necessary	270,20
11366	Dilated fundus examination with Fundus lens **Rule:** can be billed in addition to 11001 or 11046 when necessary	268,00
11423	Visual field – Non threshold Testing **Rule:** can be billed in addition to 11001 or 11046 when necessary	172,90
11443	Visual Field – Threshold Testing **Rule**: can be billed in addition to 11001 or 11046 when necessary	302,60
11246	Colour Vision Evaluation **Rule:** can be billed in addition to 11001 or 11046 when necessary	198,80
11265	Contrast Sensitivity Evaluation **Rule:** can be billed in addition to 11001 or 11046 when necessary	122,30
11604	Photography of Anterior Segment **Rule:** can be billed in addition to 11001 or 11046 when necessary	86,40
11624	Photography of Fundus **Rule**: can be billed in addition to 11001 or 11046 when necessary	138,30
11702	Pachymetry **Rule**: can be billed in addition to 11001 or 11046 when necessary	121,00
11802	Optical Coherence Tomography (OCT) Health screening **Rule:** can be billed in addition to 11001 or 11046 when necessary	250,70
11803	Optical Coherence Tomography (OCT) Anterior **Rule:** can be billed in addition to 11001 or 11046 when necessary	181,50
11804	Optical Coherence Tomography (OCT) Posterior **Rule:** can be billed in addition to 11001 or 11046 when necessary	216,10
11906	Lacrimal Drainage System Patency **Rule:** can be billed in addition to 11001 or 11046 in cases such as chemical or vapour exposure	319,80
15000	Removal of corneal foreign body **Rule:** Can be billed in isolation or with 11001 or 11046 or 11061 or 15025 or 15030	207,50
15002	Removal of corneal foreign body **Rule:** Can be billed in isolation or with 11001 or 11046 or 11061 or 15025 or 15030	303,00
15004	Removal of corneal foreign body **Rule:** Can be billed in isolation or with 11001 or 11046 or 11061 or 15025 or 15030	393,40
15025	Management of ocular pathology **Rule** : Can not be billed with Not with 15030 or 11001 or 11046 or 11061	760,70
15030	Management of ocular pathology – follow up **Rule** : Can not be billed with Not with 15025 or 11001 or 11046 or 11061	544,60
11141	Refractive Status evaluation **Note:** Appropriate after IOD incident to monitor recovery of the eye.	216,10
11183	Keratometry **Note:** Appropriate for fitting of contact lens or monitoring of corneal recovery after IOD to the eye	108,10
11202	Tonometry without anaesthetic **Note:** After ocular IOD cases only	129,70
11212	Tonometry with anaesthetic **Note:** After ocular IOD cases only	172,90
11402	Visual field – screening **Note**: Relevant in cases of head and/or ocular injury	138,30
11838	Glaucoma investigation **Note:** Relevant in cases of ocular injury	224,80

LENS CODE	DESCRIPTION	RAND
11501	Dispensing fee – single vision basic **Rule**: Only with replacement of spectacle lenses code 81BS001	77,80
11521	Dispensing fee – Bifocals **Rule**: Only with replacement of spectacle lenses code 84BS001	103,70
11541	Dispensing fee – Varifocal distance to near **Rule:** Only with replacement of spectacle lenses code 86BS001	129,70
11503	Dispensing fee – Single Vision Surfaced **Rule:** Only with replacement of spectacle lenses code 82BS001	103,70
11531	Dispensing Fee – Accommodative Support **Rule:** only with replacement of spectacle lenses code 83BS001	103,70
11540	Dispensing fee – Intermediate to near **Rule:** Only with replacement of spectacle lenses code 85BS001	103,70
Note	**For Single vision, Bifocal, Varifocal the below applies** LENS CODES: Replacement lenses after ocular injury if lenses were broken or if Rx changed due to IOD incident. **Rule:** A claim is limited to a maximum of 2. Occasionally there may be a combination of 2 different codes, but never a code starting with 8 together with a code starting with 7	
81BS001	Single Vision (standard) CR39	216,60
82BS001	Single Vison (surfaced) CR39	487,90
83BS001	Accommodative support lens	487,90
84BS001	Bifocals CR39	544,80
85BS001	Varifocal Intermediate to near	945,70
86BS001	Varifocal Distance to near	945,70
71BS001	Single Vision (standard) Glass	216,60
72BS001	Single Vison (surfaced) Glass	487,90
74BS001	Bifocal Glass	544,80
76BS001	Varifocal Distance to Near Glass	945,70
40501	Spectacle frame **Rule:** Replacement frame if damaged or lost in IOD incident	891,01
Note	**For Unbranded HRI the below applies:** LENS ENHANCEMENTS CODES: Where lenses are replaced as result of IOD, and Rx is greater than +4.00D (sphere) or -6.00D (sphere + cyl, or cyl is greater than -2.00) **Rule:** First 2 digits must align with first 2 digits of lens codes	
81UB003	Unbranded HRI single vision stock	2462,30
83UB002	Unbranded HRI Accommodative Support	1822,30
86UB006	Unbranded HRI Varifocal Distance/Near	2157,30

CONTACT LENSES	DESCRIPTION	RAND
Note and Rule	Contact lenses can be either elective or clinically essential. Elective lenses are selected as a convenience or cosmetic preference by the wearer. Clinically essential contact lenses are necessary where adequate vision can only be achieved by the application of a contact lens. Contact lenses are manufactured in a number of different materials and modalities. On a high level there are rigid and soft lenses. Both fall into 2 major sub-categories: **Rigid:** corneal and scleral. Rigid lenses can last for a number of years, if well cared. **Soft lenses**: Disposable and Non-disposable. Non-disposable mostly have a lifespan of 12 months. Disposable may be replaceable daily, weekly, or monthly. **Rule:** Where contact lenses were damaged in the IOD, they will only require replacement once. The employee would have been responsible for routine replacement prior to the IOD incident, and is therefore responsible thereafter. **Rule:** Where the IOD incident had made contact lenses clinically essential they will require ongoing replacement as per the replacement schedule. **Rule: MOTIVATION IS REQUIRED FOR CONTACT LENSES AND WILL BE PAYABLE BASED ON THE REASONABILITY DETERMINED BY THE FUND.**	
24022	Rigid contact lens Where rigid contact lens is damaged in IOD, or injury to eye requires rigid lens	
24024	Rigid scleral contact lens	
93800	Contact lens material benefit	
Note	Where IOD incident resulted in Low Vision status (normal visual function cannot be achieved with spectacles or contact lenses) one or more low vision devices are appropriate.	
61013	LVA – Single Element	
61114	LVA – Multiple Elements Fixed Focus	
61215	LVA – Multiple Element Variable focus	
61318	LVA – Electronic	
61320	Software aided vision program	

ENDED CODES	DESCRIPTION	RAND
70081	Optometric examination and visual field screening consultation	556,78
70021	Optometric re-examination withing six months of 70081 followup	318,21
70503	Walking Stick/Cane for the blind	347,00

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

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