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Contents

DEPARTMENT OF EMPLOYMENT AND LABOUR

NOTICE 924 OF 2022

PHYSIOTHERAPY 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.

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

PHYSIOTHERAPY TARIFF OF FEES AS FROM 1 APRIL 2022	
	GENERAL RULES
RULE	**DESCRIPTION**
001	Unless timely steps (i.e. 24 hours prior to the appointment) are taken to cancel an appointment the relevant fee may be charged to the employee, but shall not be payable by Compensation Fund. Each case shall, however, be considered on merit and, if circumstances warrant, no fee shall be charged.
003	Newly hospitalised patients will be allowed up 20 sessions without pre-authorisation. If further treatment is necessary after a series of 20 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. Hospitalised patients admitted to ICU and High Care following an emergency will not require pre-authorization for rehabilitation services. Referral letter with motivation, initial treatment plan, progress report should be submitted with the invoice. Notification of admission to these units must be sent to the Fund by the admitting hospital within 72 hours of such admission. All the cases are subject to case management.
004	AM and PM treatment sessions, applicable only to hospitalised patients, should be specified and medically motivated for on the progress rehabilitation report.
005	**Out Patient** : In cases of out-patients, all treatment sessions will need pre-authorisation. All request for pre-authorisation must be based on clinical need, best practice and be in the best interest of the patient. 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 preauthorisation. Practitioners will be allowed up to ten (10) treatment sessions to continue with treatment after submitting their request while awaiting response from the Fund. The rehabilitation professional must submit monthly progress report.
006	Where emergency treatment is provided: a. during working hours, and the provision of such treatment requires the practitioner to leave his or her practice to attend to the patient in hospital; or b. after working hours the fee for such visits shall be the total fee plus 50%. a. "emergency treatment" means a bona fide, justifiable emergency physiotherapy procedure, where failure to provide the procedure immediately would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy; and b. "working hours" means 8h00 to 17h00, Monday to Friday.
007	The physiotherapist shall submit his / her invoice for treatment to the employer of the employee concerned and can also submit invoices directly to the Fund using available electronic methods.
008	When an employee is referred for physiotherapy treatment after a surgical procedure, a new treatment plan needs to be provided to the Fund.
009	When more than one condition requires treatment and each of these conditions necessitates an individual treatment, they shall be charged as individual treatments. Full details of the nature of the treatments and the diagnosis or diagnostic codes shall be stated.
010	When the treatment times of two completely separate and different conditions overlap, the fee shall be the full fee for one condition and 50% of the fee for the other condition. Both conditions must be specified. Modifier 0010 must then be quoted after the appropriate code number to indicate that this rule is applicable.
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 invoice for services rendered will be assessed and added without VAT. VAT is then calculated and added to the final payment amount
013	Where the physiotherapist performs treatment away from the treatment rooms, travelling costs being more than 16 kilometres in total) to be charged according to the National Treasury regulation. If more than one employee is attended to during the course of a trip, the full travelling expenses must be 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 nursing home or hospital. Modifier 0014 must be quoted after each code
015	The services of a physiotherapist shall be approved 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.
016	Physiotherapists, Occupational Therapist and Chiropractors may not provide simultaneous treatment at the same time on a day, but may treat the same patient. Multidisciplinary treatment goals must be considered and the best placed service provider to achieve the rehabilitation goal must address that specific goal.
	Modifiers
Abbreviation	**DESCRIPTION**
AM	Additional Modifier
IM	Information Modifier
RM	Reduction Modifier
Modifier	**DESCRIPTION**
014	IM: Physiotherapy services rendered to an in-patient in a nursing home or hospital.
015	IM: Physiotherapy services rendered as an outpatient Refer to rule 005
0006	AM: Emergency modifier - Add 50% of the total fee for the treatment Refer to rule 006
0010	RM: Only 50% of the fee for the second condition may be charged Refer to rule 010
0013	Travelling costs (being more than 16 kilometres in total) according to National Treasury regulation. Refer to rule 013

	TARIFF CODES	
Note	Only one of the following codes can be claimed per session/consultation: 72925,72926,72327, 72921,72923,72928,72927,72501 and 72503	
1	REHABILITATION	RAND
72501	Rehabilitation where the pathology requires the undivided attention of the physiotherapist. Duration: 30min. This code can only be claimed once per treatment session	510.36
72503	Rehabilitation for Central Nervous System disorders - condition to be clearly stated and fully documented (No other treatment modality may be charged in conjunction with this). Duration: 60min. This code can only be claimed once per treatment session	1020.9
72509	Rehabilitation. Each additional full 15 mins needs to be medically motivated with a clear indication where pathology requires the undivided attention of the physiotherapist, This code can only be claimed once per treatment session. Item 72509 can be added to 72501 and 72503.	163.28
2	EVALUATION	
72701	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 fully documented and submitted at the initiation of treatment.	293.97
72702	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 fully documented and submitted at the initiation of treatment. Item 72702 cannot be used with 72701	440.55
72703	One complete re-assessment or one physical performance test during the course of treatment. To be used only once per episode of care. This should be fully documented and a rehabilitation progress report provided to the Compensation Fund. This code will apply to patients that have been discharged and are now re -admitted, if there has been a gap in treatment or during the course of his treatment to ensure treatment goals and outcomes are aligned.	146.6
3	VISITING CODES	
72901	Consultation: Treatment at a nursing home: Relevant fee plus (to be charged only once per day and not with every hospital visit).	107.42
72903	Consultation: Domiciliary treatments : Apply only when medically motivated and pre-authorised: relevant fee plus.	195.46

4	OTHER	
72939	Cost of material: Items to be charged (exclusive of VAT) at net acquisition price plus - 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands. 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	
72925	**Level 1 chest pathology, which includes either or / and:** > Vibration =10 units > Percussion =16.1 units > Nebulisation = 10 units >Suction: Level 1 (including sputum specimen taken by suction) = 5 units **applies to non-ventilated patients only**	**481.27**
72926	**Level 2 chest pathology which includes either or / and:** > Vibration =10 units > Percussion = 16.1 units >Postural drainage = 10 units > Upper respiratory nebulisation and/or lavage = 10 units > Suction: Level 2 (Suction with involvement of lavage as a treatment in a special unit situation or in the respiratory compromised patient) e.g. Tracheostomy = 20.09 units > Pre- and *post-operative exercises and/or breathing = 10 units* ***Applies to High Care and non-ventilated patients***	**795.19**
72327	**Level 3 chest pathology which includes either or / and:** > Vibration =10 units > Percussion = 16.1 units >Postural drainage = 10 units > Upper respiratory nebulisation and/or lavage = 10 units > Intermittent positive pressure ventilation = 10 units > Suction: Level 2 (Suction with involvement of lavage as a treatment in a special unit situation or in the respiratory compromised patient = 20.09 units > Bagging (used on the intubated unconscious patient or in the severely respiratory distressed patient) = 5 units > Pre- and post-operative exercises and/or breathing = 10 units applies for ventilated patients only	**1009.47**
72921	**Simple spinal treatment which includes either or / and:** MANIPULATION/MOBILISATION OF JOINTS OR IMMOBILISATION which includes either or / and: > Spinal (Manual spinal mobilisation) = 15 units > Pre meditated manipulation =10 units > Immobilisation (excluding materials) =15 units (Rule 008 does not apply) > Pre- and post-operative exercises and/or breathing exercises = 10 units	**706.78**
72923	**Complex spinal treatment which includes either or / and:** MANIPULATION/MOBILISATION OF JOINTS OR IMMOBILISATION which includes either or / and: > Spinal (Manual spinal mobilisation) = 15 units > Pre meditated manipulation = 10 units > Immobilisation (excluding materials) =15 units (Rule 008 does not apply) > Rehabilitation for Central Nervous System disorders - condition to be clearly stated and fully documented (No other treatment modality may be charged in conjunction with this = 55units > Traction - 10 units > Pre- and post-operative exercises and/or breathing exercises = 10 units	**1020.9**
72928	**Simple soft tissue / peripheral joint injuries or other general treatment which includes either or / and:** > Massage = 10 units > Neural tissue mobilisation = 20 units > Pre- and post-operative exercises and/or breathing exercises = 10 units	**706.78**

72927	**Complex soft tissue / peripheral joint injuries or other general treatment** > Massage = 10 units > Myofacial release/soft tissue mobilisation, one or more body parts = 20 units > Neural tissue mobilisation = 20 units > Pre- and post-operative exercises and/or breathing exercises = 10 units	**923.17**

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	23.50
Self adhesive disposable electrodes (one set per employee is payable)	1	74.65
Sports		
Taping / Strapping (type & quantity must be specified)		
Elastoplast 75mm x 4.5	1	160.13
Coverol	1	119.14
Leukotape	1	160.13
Magic Grip Spray	1	115.65
Fixomull	1	133.48
Leukoban 50-75mm x 4.5m	1	62.34
Other		
Incontinence electrodes for pathway EMG	1	355.75
EMG flat electrodes	1	30.15
(should be medically justified)		

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	23.5
Self adhesive disposable electrodes (one set per employee is payable)	1	74.65
Sports		
Taping / Strapping (type & quantity must be specified)		
Elastoplast 75mm x 4.5	1	160.13
Coverol	1	119.14
Leukotape	1	160.13
Magic Grip Spray	1	115.65
Fixomull	1	133.48
Leukoban 50-75mm x 4.5m	1	62.34
Other		
Incontinence electrodes for pathway EMG	1	355.75
EMG flat electrodes	1	30.15
(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 Orthotist / Prosthetist to the same employee

NAME OF PRODUCT	UNIT	APPROX UNIT PRICE(excl VAT)
Hot / cold packs	1	255
Braces		
Cervical collar	1	132
Lumbar brace	1	545
Standard heel cups	pair	165
Cliniband	1	56.82
Fit band 5.5cm	1	14.41
Fit band 30cm	1	50.52
Peak flow meter	1	332.59
Peak flow meter	2	3.51

Compensation for Occupational Injuries and Disease Act, 1993 (Act No. 130 of 1993)

CLAIM NUMBER								

PART 1 – INITIAL EVALUATION AND PLAN					
EMPLOYEE DETAILS					
First Name/s		Surname			
Identity Number		Mobile No.			
Address		Postal Code			
EMPLOYER DETAILS					
Name					
Address		Postal Code			
ACCIDENT DETAILS					
Date of Accident	D D M M Y Y Y Y				
REFERRING MEDICAL PRACTITIONER DETAILS					
Name		Practice No.		Referral Date:	D D M M Y Y Y Y
PHYSIOTHERAPIST'S DETAILS					
Physiotherapist		Practice No.		Account No.	
1. First Consultation Date	D D M M Y Y Y Y				

NOTE: For sections 2 to 6, please provide evidence from objective assessment results e.g. if the patient initially presented with pain, please provide the score from the pain measure used, such as the Borg scale; if the patient initially presented with limited ROM at a particular joint, please provide the initial, current and anticipated joint range measurements in degrees.

2. Indicate initial clinical presentation:

3. Indicate patient's symptoms and function:

4. Indicate any complicating factors that may prolong rehabilitation or delay recovery:

5. Overall goal treatment:

6. Treatment plan for proposed session:

Signature of Physiotherapist		Date	

Compensation for Occupational Injuries and Disease Act, 1993 (Act No. 130 of 1993)

CLAIM NUMBER								

PART 2 – TREATMENT AND PROGRESS (MONTHLY)

EMPLOYEE DETAILS			
First Name/s		Surname	
Identity Number		Mobile No.	
Address		Postal Code	
EMPLOYER DETAILS			
Name			
Address		Postal Code	
ACCIDENT DETAILS			
Date of Accident	D D M M Y Y Y Y		
REFERRING MEDICAL PRACTITIONER DETAILS			
Name		Practice No.	Referral Date: D D M M Y Y Y Y
PHYSIOTHERAPIST'S DETAILS			
Physiotherapist		Practice No.	Account No.

1. No. of sessions | Start Date D D M M Y Y Y Y | End Date D D M M Y Y Y Y

2. Progress Achieved: *[**Relate your progression to your outcome measures stated in Part 1 Report** - Pain VAS, Strength (Oxford Scale), ROM (Degrees), Functional Ability, Mode of Ventilation, etc.]*

3. Did the patient undergo surgical procedures during this treatment period? Yes | No

4. Surgical procedures date/s and procedure/s done

5. Treatment plan for proposed treatment sessions: *[**Must correlate with the plan on the Part 1 Report** - must become more specific as treatment evolves e.g. continue increasing joint Range of Motion (degrees) and Strength (Oxford Scale), Train Proprioception, Functional Rehabilitation, 6-minute walk test. Requiring less ventilatory support]*

Signature of Physiotherapist		Date	

Compensation for Occupational Injuries and Disease Act, 1993 (Act No. 130 of 1993)

CLAIM NUMBER								

PART 3 – FINAL PROGRESS REPORT																							
EMPLOYEE DETAILS																							
First Name/s															Surname								
Identity Number															Mobile No.								
Address																		Postal Code					
EMPLOYER DETAILS																							
Name																							
Address																		Postal Code					
ACCIDENT DETAILS																							
Date of Accident	D	D	M	M	Y	Y	Y	Y															
REFERRING MEDICAL PRACTITIONER DETAILS																							
Name										Practice No.						Referral Date:	D	D	M	M	Y	Y	Y	Y
PHYSIOTHERAPIST'S DETAILS																							
Physiotherapist										Practice No.						Account No.							

1. Date of Final Treatment	D	D	M	M	Y	Y	Y	Y

2. Progress Achieved: ***[This must correlate with Part 1 & 2 Reports.]***

3. Is the employee fit for his/her normal work?	Yes		No
4. Is the employee fully rehabilitated / has the employee obtained highest level of function?	Yes		**No***

5. ***If NO**, describe in detail any present permanent anatomical defect and / or impairment of function as a result of the accident (ROM, muscle strength, Functional Abilities, if applicable- refer back to your initial assessments.) For example, if the patient has permanent pain, please provide the score from the pain measure used, such as the Borg Scale. If the patient has permanently limited ROM at a particular joint, please provide the final joint range measurements in degrees.

Signature of Physiotherapist		Date	

Compensation for Occupational Injuries and Disease Act, 1993 (Act No. 130 of 1993)

PHYSIOTHERAPIST'S MOTIVATION FOR MORE THAN ONE PHYSIOTHERAPY TREATMENT PER DAY

Date:

Patient Name :_____

Referring Doctor: _____

Identification No:_____

Date of Injury :_____

Claim No :_____

Diagnosis :_____

_____

_____

_____

Reason for B.D physiotherapy

☐ **Deterioration / Alteration in Patient's Respiratory Condition.**

☐ **Poor Mobility, Reduced Musculo – Skeletal Strength, Decrease Range of Movement and / or Reduced Exercise Tolerance.**

☐ **Gait difficulties – including poor balance and coordination.**

☐ **Complicated Medical case with multiple injuries**

☐ **General deterioration of the patient's condition.**

☐ **Requiring maximal assistance (usually 2 physiotherapists) with Activities of Daily Living / Physiotherapy in order to regain Functional Independence due to his Condition/diagnosis.**

☐ **Other – please specify:** _____

_____

Physiotherapist: _____ **Signature:**_____

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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