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Contents

GENERAL NOTICES • ALGEMENE KENNISGEWINGS

DEPARTMENT OF EMPLOYMENT AND LABOUR

NOTICE 3048 OF 2025

OCCUPATIONAL THERAPY GAZETTE 2025

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

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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, Nomakhosazana Meth, Minister of Employment and Labour, hereby give notice that, after consultation with the Compensation Board and acting under powers vested in me by section 97 of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No.130 of 1993), prescribe the scale of "Fees for Medical Aid" payable under section 76, inclusive of the General Rule applicable thereto, appearing in the Schedule, with effect from 1 April 2025.
2. Medical Tariffs will increase by 6% for the financial year 2025/26.
3. The fees appearing in the Schedule are applicable in respect of services rendered from 1 April 2025 and exclude 15% VAT

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Ms. N Meth, MP

MINISTER OF EMPLOYMENT AND LABOUR

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GENERAL INFORMATION

POPI ACT COMPLIANCE

In terms of Protection of Personal Information Act, 2013 (POPI Act), the Compensation Fund wants to assure Employees and the Medical Service Providers that all personal information collected is treated as private and confidential. The Compensation Fund has put in place the necessary safeguards and controls to maintain confidentiality, prevent loss, unauthorised access and damage to information by unauthorised parties.

1. MEDICAL SERVICE PROVIDERS REGISTRATION REQUIREMENTS WITH THE COMPENSATION FUND

1.1. The Compensation Fund requires that any Medical Service Provider, providing medical treatment to patients in terms of the COID Act, must be registered with The Compensation Fund as follows:

1.1.1. Copies of the following documents must be submitted to the nearest Labour Centre

a. A certified identity document of the practitioner

b. Certified valid BHF certificate

c. Recent bank statement with bank stamp or bank letter

d. Proof of practice address not older than 3 months.

e. Submit SARS VAT registration number/ certificate if VAT registered. If this is not provided the Medical Service Provider will be registered as a Non VAT vendor.

f. A power of attorney is required where the MSP has appointed a third party for administration of their COID claims.

1.1.2. A duly completed original Banking Details form (WAC 33) that can be downloaded in PDF from the Department of Employment and Labour Website (www.labour.gov.za).

1.1.3. Submit the following additional information on the Medical Service Provider letterhead, Cell phone number, Business contact number, Postal address and Email address. The Fund must be notified in writing of any changes in order to effect necessary changes.

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Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

2. REGISTERING WITH THE COMPENSATION FUND AS AN ONLINE SYSTEM USER FOR MEDICAL SERVICE PROVIDERS

2.1. To register as an online user of the claims processing system, COMPEASY, the following steps must be followed:

2.1.1. Register as an online user with the Department of Employment and Labour website (www.labour.gov.za)

2.1.2. Register on the CompEasy application having the following documents to upload:

- A certified copy of identity document (not older than a month from the date of application)
- Certified valid BHF certificate
- Proof of address not older than 3 months

2.2. In the case where a medical service provider wishes to appoint a proxy to interact on the claims processing system the following ADDITIONAL documents must be uploaded:

- An appointment letter for proxy (the template is available online)
- The proxy's certified identity document (not older than a month from the date of application)
- There are instructions online to guide a user on successfully registering (www.compeasy.gov.za)

3. THIRD PARTIES TRANSACTING ON BEHALF OF MEDICAL SERVICE PROVIDERS

3.1. Third Parties that provide administration services on COID medical invoices on behalf of medical service providers must take note of the following:

3.1.1. A third party transacting with the Fund, must be in a position to obtaining a copies of the original claim documents and medical invoices from medical service providers.

3.1.2. The third party must keep such records in their original state as received from the medical service provider and must furnish the Compensation Commissioner with such documents on request for the purposes of auditing.

3.2. The Fund will not provide or disclose any information related to a medical service provider, represented by a third party, where such information was obtained or relates to a period prior to them contracting to a third party.

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Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

4. THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

4.1. Medical Service Providers are advised to take note of the following as it pertains to the treatment of patients in relation to the Compensation for Occupational Injuries and Diseases Act of 1993 (COID Act):

4.1.1. An employee as defined in the COID Act of 1993, is at liberty to choose their preferred medical service provider without interference, as long as it is exercised reasonably and without prejudice to the employee or the Compensation Fund.

4.1.2. 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 its employees, e.g. Hospital, nursing and other medical services — Section 78 of the COID Act refers.

4.1.3. In terms of Section 42 of the COID Act, the Compensation Fund may refer an injured employee to a specialist medical service provider designated by the Director General for a medical examination and report.

4.1.4. In terms of section 76,3(b) of the COID Act, no amount in respect of medical expenses shall be recoverable from the employee.

4.1.5. In the event of a change of a medical service provider attending to a case, the first treating doctor in attendance will, except where the case is transferred to a specialist, be regarded as the principal treating doctor.

4.1.6. To avoid disputes regarding the payment for services rendered, medical service providers should refrain from treating an employee already under treatment by another medical practitioner without consulting/informing the principal treating doctor.

4.1.7. Any changes of medical service providers must have sufficient reasons existing for such a change which must be communicated to the Compensation Fund.

4.1.8. 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 registered and liability for the claim is accepted by the Compensation Fund.

4.1.9. An employee seeks medical advice at their own risk. If such an employee presents themselves to a medical service provider as being entitled to treatment in terms of the COID Act, whilst having failed to inform their employer and/or the Compensation Fund of any possible grounds for a claim, the Compensation Fund cannot accept responsibility for the settlement of medical expenses incurred under such circumstances.

4.1.10. The Compensation Fund may have reasons to repudiate a claim lodged with it, in such circumstances, the employee would be in the same position as any other member of the public regarding payment of their medical expenses.

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Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

5. OVERVIEW OF THE COID CLAIMS PROCESS

5.1. All claims lodged in the prescribed manner with the Compensation Fund are subjected to the following process:

5.1.1. New claims are registered by the Employers with the Compensation Fund in the prescribed manner. Details of and progress of the claim can be viewed on the online processing system for registered users of the system.

5.1.2. Proof of identity is required in the form of a copy of an Identity document/card, will be required in order for a claim to be registered with the Compensation Fund. In the case of foreign nationals, the proof of identity (passport) must be certified.

5.1.3. All supporting documentation submitted to the Compensation Fund must reflect the identity and claim numbers of the employee.

5.1.4. The allocation of a claim number to a claim after the registration thereof by the Compensation Fund, does not constitute acceptance of liability for a claim. It indicates that the injury on duty has been reported to the Compensation Fund and acknowledged.

5.1.5. When liability for a claim is accepted by the Compensation Fund in terms of the COID Act, reasonable medical expenses, related to the medical condition shall be paid to medical service providers, that treat the employees, in accordance to approved tariffs, billing rules and procedures as published in the medical tariff gazettes of the Compensation Fund.

5.1.6. If a claim is repudiated in terms of the COID Act, medical expenses, will not be payable by the Compensation Fund. The employer and the employee will be informed of this decision and the injured employee will be liable for payment of medical costs incurred.

5.1.7. In the event of insufficient claim information being made available to the Compensation Fund, the claim will be rejected until the outstanding information is submitted and liability can be determined.

5.1.8. Manner of payment of medical benefits for Compensation Fund claims, where liability has been accepted (adjudicated) on or after 1 April 2025.

5.1.9. All medical invoices for accepted claims must be submitted, in the prescribed manner within 24 months of the date of acceptance of liability. Medical invoices received after said time frame will be considered as late submission of invoices and may be rejected.

5.1.10. All service providers should be registered on the Compensation Fund claims processing system in order to capture medical invoices and medical reports for medical services rendered.

5.1.11. Medical reports and medical invoices should ONLY be submitted/transmitted for claims that The Compensation Fund has accepted liability for and thus reasonable medical expenses are payable.

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Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

6. BILLING REQUIREMENTS FOR MEDICAL SERVICES PROVIDED TO INJURED/DISEASED EMPLOYEES

6.1. Medical Reports:

In terms of Sec 74(1)(2)(3)(4) and (5) of COID Act, Submission of Medical Report; Medical Service provider are advised to take note of the following:

6.1.1. The first medical report (W. CL 4), completed after the first consultation must confirm the clinical description of the injury/disease. It must also detail any procedure performed and any referrals to other medical service providers where applicable.

6.1.2. All follow up consultations must be completed on a Progress Medical Report (W.CL5). Any operation/procedure performed must be detailed therein and any referrals to other medical service providers where applicable.

6.1.3. A progress medical report is considered to cover a period of 30 days, with the exception where a procedure was performed during that period, then an additional operation report will be required.

6.1.4. Only one medical report is required when multiple procedures are done on the same service date.

6.1.5. When the injury/disease being treated stabilises a Final Medical Report must be completed (W.CL 5F).

6.1.6. Medical Service Providers are required to keep copies of medical reports which should be made available to the Compensation Commissioner when requested.

NB: Hospitals will be required from the 1st April 2025 to provide patient records when submitting medical invoices for services provided.

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Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

7. MINIMUM INFORMATION REQUIREMENTS FOR MEDICAL INVOICES SUBMITTED TO THE COMPENSATION FUND

The following must be indicated on a medical invoice in order to be processed by the Compensation Fund:

1. The allocated Compensation Fund claim number
2. Name and ID number of employee
3. Name and Compensation Fund registration number of Employer, as indicated on the Employers Report of Accident (W.CL 2)
4. DATES:
    a. Date of accident
    b. Date of service (From and to)
5. Medical Service Provider, BHF practice number
6. VAT registration number of Medical Service Provider: VAT will not be applied if a VAT registration number is not supplied on the invoice
7. Tariff Codes:
    a. Tariff code applicable to injury/disease, are as published tariff gazettes.
    b. Amount claimed per code, quantity and the total amount of the invoice.
8. VAT:
    a. The tariff amounts published in the tariff guides exclude VAT.
    b. All invoices for services rendered will be assessed without VAT.
    c. VAT will be applied to VAT registered vendors (MSP's) without being rounded off.
    d. With the exception of the following:
        i. "PER DIEM" tariffs for Private Hospitals that already are VAT inclusive.
        ii. Certain VAT exempted codes in the Private Ambulance tariff structure.
9. All pharmacy or medication invoices must be accompanied by the original script(s)

NB!! All pharmaceuticals will be processed in accordance with Nappi file codes.

10. Where applicable the referral letter from the treating practitioner must accompany the medical service providers' invoice.
11. All medical invoices must be submitted with invoice numbers to prevent system rejections.
12. Duplicate invoices should not be submitted.
13. Compensation Fund does not accept submission of running accounts /statements, but will reject upfront at switch level.

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

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Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

8. REQUIREMENTS FOR SWITCHING MEDICAL INVOICES WITH THE COMPENSATION FUND

A switching provider must comply with the following requirements:

1. Register with the Compensation Fund as an employer where applicable in terms of the COID Act 1993
2. Host a secure FTP (or SFTP) server to ensure encrypted connectivity with the Fund. This requires that they ensure the following:
    a. Disable Standard FTP because is now obsolete. ...and use latest version and reinforce FTPS protocols and TLS protocols.
    b. Use Strong Encryption and Hashing.
    c. Place Behind a Gateway.
    d. Implement IP Blacklists and Whitelists.
    e. Harden Your FTPS Server.
    f. Utilize Good Account Management.
    g. Use Strong Passwords.
    h. Implement File and Folder Security.
    i. Secure your administrator, and require staff to use multifactor authentication.
3. Submit and complete successful test file after registration before switching the invoices.
4. Verify medical service provider's registration with the Board of Healthcare Funders of South Africa.
5. Submit medical invoices with gazetted COIDA tariffs that are published annually.
6. Comply with medical billing requirements of the Compensation Fund.
7. Single batch submitted must have a maximum of 150 medical invoices.
8. Eliminate duplicate invoices before switching to the Fund.
9. File name must include a sequential batch number in the file naming convention.
10. File names to include sequential number to determine order of processing.
11. Only pharmacies should claim from the NAPPI file.

PLEASE NOTE:

Failure to comply with the above requirements will result in deregistration / penalty imposed on the switching house.

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Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

COMPEASY ELECTRONIC INVOICING FILE LAYOUT

*** Mandatory fields**

FIELD	DESCRIPTION	Max Length	DATA TYPE	MANDATORY
BATCH HEADER				
1	Header identifier = 1	1	Numeric	*
2	Switch internal Medical aid reference number	5	Alpha	
3	Transaction type = M	1	Alpha	
4	Switch administrator number	3	Numeric	
5	Batch number	9	Numeric	*
6	Batch date (CCYYMMDD)	8	Date	*
7	Scheme name	40	Alpha	*
8	Switch internal	1	Numeric	
DETAIL LINES				
1	Transaction identifier = M	1	Alpha	*
2	Batch sequence number	10	Numeric	*
3	Switch transaction number	10	Numeric	*
4	Switch internal	3	Numeric	
5	CF Claim number	20	Alpha	*
6	Employee surname	20	Alpha	*
7	Employee initials	4	Alpha	*
8	Employee Names	20	Alpha	*
9	BHF Practice number	15	Alpha	*
10	Switch ID	3	Numeric	
11	Patient reference number (account number)	11	Alpha	*
12	Type of service	1	Alpha	
13	Service date (CCYYMMDD)	8	Date	*
14	Quantity / Time in minutes	7	Decimal	*
15	Service amount	15	Decimal	*
16	Discount amount	15	Decimal	*
17	Description	30	Alpha	*
18	Tariff	10	Alpha	*
19	Service fee	1	Numeric	
20	Modifier 1	5	Alpha	
21	Modifier 2	5	Alpha	
22	Modifier 3	5	Alpha	
23	Modifier 4	5	Alpha	
24	Invoice Number	10	Alpha	*
25	Practice name	40	Alpha	*
26	Referring doctor's BHF practice number	15	Alpha	
27	Medicine code (NAPPI CODE)	15	Alpha	*
28	Doctor practice number - sReferredTo	30	Numeric	
29	Date of birth / ID number	13	Numeric	*
30	Service Switch transaction number – batch number	20	Alpha	
31	Hospital indicator	1	Alpha	*
32	Authorisation number	21	Alpha	*
33	Resubmission flag	5	Alpha	*
34	Diagnostic codes	64	Alpha	*
35	Treating Doctor BHF practice number	9	Alpha	

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Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

FIELD	DESCRIPTION	Max Length	DATA TYPE	MANDATORY
36	Dosage duration (for medicine)	4	Alpha	
37	Tooth numbers		Alpha	*
38	Gender (M, F)	1	Alpha	
39	HPCSA number	15	Alpha	
40	Diagnostic code type	1	Alpha	
41	Tariff code type	1	Alpha	
42	CPT code / CDT code	8	Numeric	
43	Free Text	250	Alpha	
44	Place of service	2	Numeric	*
45	Batch number	10	Numeric	
46	Switch Medical scheme identifier	5	Alpha	
47	Referring Doctor's HPCSA number	15	Alpha	*
48	Tracking number	15	Alpha	
49	Optometry: Reading additions	12	Alpha	
50	Optometry: Lens	34	Alpha	
51	Optometry: Density of tint	6	Alpha	
52	Discipline code	7	Numeric	
53	Employer name	40	Alpha	*
54	Employee number	15	Alpha	*
55	Date of Injury (CCYYMMDD)	8	Date	*
56	IOD reference number	15	Alpha	
57	Single Exit Price (Inclusive of VAT)	15	Numeric	
58	Dispensing Fee	15	Numeric	
59	Service Time	4	Numeric	
60				
61				
62				
63				
64	Treatment Date from (CCYYMMDD)	8	Date	*
65	Treatment Time (HHMM)	4	Numeric	*
66	Treatment Date to (CCYYMMDD)	8	Date	*
67	Treatment Time (HHMM)	4	Numeric	*
68	Surgeon BHF Practice Number	15	Alpha	
69	Anaesthetist BHF Practice Number	15	Alpha	
70	Assistant BHF Practice Number	15	Alpha	
71	Hospital Tariff Type	1	Alpha	
72	Per diem (Y/N)	1	Alpha	
73	Length of stay	5	Numeric	*
74	Free text diagnosis	30	Alpha	
TRAILER				
1	Trailer Identifier = Z	1	Alpha	*
2	Total number of transactions in batch	10	Numeric	*
3	Total amount of detail transactions	15	Decimal	*

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Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

MSPs PAID BY THE COMPENSATION FUND

Discipline Code :	Discipline Description :
004	Chiropractors
009	Ambulance Services - Advanced
010	Anesthesiology
011	Ambulance Services - Intermediate
012	Dermatology
013	Ambulance Services - Basic
014	General Medical Practice
015	General Medical Practice
016	Obstetrics and Gynecology (Occupational related cases)
017	Pulmonology
018	Specialist Medicine
019	Gastroenterology
020	Neurology
021	Cardiology (Occupational Related Cases)
022	Psychiatry
023	Medical Oncology
024	Neurosurgery
025	Nuclear Medicine
026	Ophthalmology
028	Orthopaedic
030	Otorhinolaryngology
034	Physical Medicine
035	Emergency Medicine Independent Practice Speciality
036	Plastic and Reconstructive Surgery
038	Diagnostic Radiology
039	Radiography
040	Radiation Oncology
042	Surgery Specialist
044	Cardio Thoracic Surgery
046	Urology
049	Sub-Acute Facilities
052	Pathology
054	General Dental Practice
055	Mental Health Institutions
056	Provincial Hospitals
057	Private Hospitals
058	Private Hospitals
059	Private Rehab Hospital (Acute)
060	Pharmacy
062	Maxillo-facial and Oral Surgery
064	Orthodontics
066	Occupational Therapy
070	Optometry
072	Physiotherapy
075	Clinical technology (Renal Dialysis and Perfusionists only)

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Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

076	Unattached operating theatres / Day clinics
077	Approved U O T U / Day clinics
078	Blood transfusion services
079	Hospices/Frail Care
082	Speech therapy and Audiology
083	Hearing Aid Acoustician
084	Dietetics
086	Psychology
087	Orthotics & Prosthetics
088	Registered nurses (Wound Care and Nephrology only)
089	Social worker
090	Clinical services : (Wheelchairs and Gases only)
094	Prosthodontic

OCCUPATIONAL THERAPY TARIFF OF FEES AS FROM 1 APRIL 2025 (PRACTICE TYPE 066)	
General Rules	
Rule	**Rule Description**
001	Unless timely steps are taken (at least two hours) to cancel an appointment for a consultation the relevant consultation fee shall be payable by the employee.
003	The service of an occupational therapist shall be available only on written referral by a treating doctor. The medical treating doctor must clearly indicate the reason for the referral, relationship to the original injury. The referral may be on the service providers (Occupational therapy practice) letterhead, provided it is signed by the referring doctor.
004	Newly hospitalised patients will be allowed up to 20 sessions without pre-authorization. If further treatment is necessary after a series of 20 treatment sessions for the same condition, the treating doctor must submit a motivation with treatment plan to the Compensation Fund for authorization.
005	Out-patient:Patients will be allowed up to 10 sessions whilst awaiting pre-authorization. If further treatment is necessary after a series of 10 treatment sessions for the same condition, the treating doctor must submit a motivation with treatment plan to the Compensation Fund for authorization.
006	"After hours treatment" shall mean those emergency treatment sessions performed at night between 18:00 and 07:00 on the following day or during weekends between 13:00 Saturday and 07:00 Monday. Public holidays are treated as Sundays. The fee for all treatment under this rule shall be the total fee for the treatment plus 50 percent. This rule shall apply for all treatment administered in the practitioner's rooms, or at a hospital or private residence (only by arrangement when the patient's condition necessitates it). Modifier 0006 must then be quoted after the appropriate tariff code to indicate that this rule is applicable.
008	The provision of aids or assistive devices shall be charged at cost. Modifier 0008 must be quoted after the appropriate tariff code to show this rule is applicable.
009	Materials used in the construction of orthoses will be charged as per Annexure "A" for the applicable device and pressure garments will be charged as per Annexure "B" for the applicable garment. Modifier 0009 must be quoted after the appropriate tariff code to show that this rule is applicable.
010	Materials used in treatment shall be charged at cost. Modifier 0010 must be quoted after the appropriate tariff code to show that this rule is applicable.
011	When the Occupational Therapist performs treatment away from their premises conducting work visit at the employer's premises. The travelling costs more than 16 kilometres will be calculated at R4,84 per km for each kilometre travelled in own car e.g. 19 km total = 19X R4,84 = R91.96. 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 practitioner will charge for one trip). Note: POEs to be attached : work visit attendance register, work visit report and google map intake from the practice to the destination.

014	Only one Evaluation Procedure code may be billed per treatment session and utilised as per the rule of the individual code.
016	Occupational Therapists,Physiotherapists and Chiropractors may not provide simultaneous treatment at the same time on a day, but may treat the same patient. (Multidisciplinary goals must be considered and the best placed service provider to achieve the rehabilitation goal must address that specific goal).
020	The use of the work hardening codes must match the rehabilitation plan provided by the Occupational Therapist and should clearly indicate how the work hardening program will be included in their rehabilitation program and graded return to work plan. The therapist may provide a maximum of 10 sessions of group work hardening intervention per patient, where a maximum of 5 patients are treated simultaneously in the same treatment area and each patient is set up with customised work simulation tasks. Each session to take place on a separate day and to be of duration of at least 120 minutes. If more than 10 sessions are necessary the authorization must be requested from the Fund. Note: The Occupational therapist to add the confirmation of employment which must accompany the pre-authorization request for work hardening.

Modifiers

Modifier	**Modifier Description**
0017	Services rendered to hospital **in-patients**: Quote modifier 0017 on all invoices for services performed on hospital in-patients.
0018	Services rendered to **out-patient**s: Quote modifier 0018 on all invoices for services performed on hospital outpatients.
0006	Emergency modifier: add 50% of the total fee for treatment. Refer to Rule 006
0008	Aids or assistive devices should be charged at cost. Refer to Rule 008
0009	Materials used for construction of orthoses or pressure garments should be charged as per Annexures "A and B" for the applicable device and pressure garments. See Annexures "A and B" for non-standard products. Refer to Rule 009
0010	Materials used in treatment should be charged at cost. Refer to Rule 010
0011	Travelling cost according to CF agreed rates. Refer to Rule 011.
0012	A detailed report of the work assessment with signatures of the employer and the injured worker shall be submitted to the Compensation Commissioner with the invoice.

1.	**Consultation Tariff Codes**		
Code	**Code Description**	**Units**	**Rand**
66101	First consultation (5 -15 min). Charged once.	60	**842.86**
66108	Follow - up consultation (15 -30 min). May be charged twice only per week.	15	**210.72**
66109	Follow - up consultation (30 - 60 min). May be charged up to four times per week.	30	**421.43**

2.	**Evaluation Procedures**		
Code	**Code Description**	**Units**	**Rand**
66201	Observation and screening. May be charged at every treatment session as clinically appropriate.	10	**140.48**
66203	Specific evaluation for a single aspect of dysfunction (Specify which aspect). May be charged once per week as clinically appropriate.	7.5	**105.36**
66205	Specific evaluation of dysfunction involving one part of the body for a specific functional problem (Specify part and aspects evaluated). May be charged once per week as clinically appropriate.	22.5	**316.07**
66207	Specific evaluation for dysfunction involving the whole body (Specify condition and which aspects evaluated). May be charged once per three months as clinically appropriate.	45	**632.15**
66209	Specific in depth evaluation of certain functions affecting the total person (Specify the aspects assessed). May be charged once per three months as clinically appropriate.	75	**1053.58**
66211	Comprehensive indepth evaluation of the total person. (Specifiy aspects assessed). Tariff code 66211 cannot be charged together with tariff code 66136.	105	**1475.01**
66136	In depth evaluation of the total person to enable the Occupational Therapist to complete a comprehensive assessment of certain functions affecting the total person. This code can only be requested by the Compensation Fund for **Section 42** Case reviews. Tariff code 66136 cannot be charged together with tariff code 66211	218.15	**3064.51**
3.	**Measurement for Designing**		
Code	**Code Description**	**Units**	**Rand**
66213	Measurement for designing a static orthosis	10	**140.48**
66215	Measurement for designing a dynamic orthosis	10	**140.48**
66217	Measurement for designing a pressure garment for one limb orthosis	10	**140.48**
66219	Measurement for designing a pressure garment for one hand orthosis	10	**140.48**
66221	Measurement for designing a pressure garment for the trunk orthosis	10	**140.48**
66223	Measurement for designing a pressure garment for the face (chin strap only)	10	**140.48**
66225	Measurement for designing a pressure garment for the face (full face mask) orthosis	10	**140.48**
	The whole body or part thereof will be the sum total of the parts.		
4.	**Procedures for Therapy**		
Code	**Code Description**	**Units**	**Rand**
66301	Group treatment in a task centred activity, per patient (treatment time 60 minutes or more)	10	**140.48**

66303	Placement of a patient in an appropriate treatment situation requiring structuring the environment, adapting equipment and positioning the patient. This does not require individual attention for the whole treatment session	20	**280.95**
66305	Groups directed to achieve common goals per person	20	**280.95**
66307	Simultaneous treatment of two to four neuro - behavioural and stress related conditions or severe head injury patients, each with specific problems utilising individual activities, per patient (treatment time 90 minutes or more)	48	**674.29**
66308	Simultaneous treatment of two to four patients, each with specific problems utilising individual activities, per patient (treatment time 60 minutes or more)	30	**421.43**
5.	**Individual and undivided attention during treatment sessions utilising specific activity or Techniques in an intergrated treatment session (Time of treatment must be specified)**		
Code	**Code Description**	**Units**	**Rand**
66309	On level one (15min)	12	**168.57**
66311	On level two (30 min)	24	**337.15**
66313	On level three (45min)	36	**505.72**
66315	On level four (60 min)	48	**674.29**
66317	On level five (90 min)	72	**1011.44**
66319	On level six (120 min)	96	**1348.58**
6.	**Procedures for work Rehabilitation**		
Code	**Code Description**	**Units**	**Rand**
66321	Work evaluation - This includes an assessment of the inherent demands of the job and the patient's ability to perform these. A detailed report is not included in this code (charged for under 66325), but must be submitted with the referral from the medical practitioner.) Item 66321 cannot be charged together with item 66211 or 66136.	80	**1123.82**
66323	Work Visit Evaluation of the job tasks by observing while the patient or a colleague in the same role performs the job tasks. May include discussing possible adaptations to the process or the work station and making the necessary recommendations to enable a patient to return to work. **Rule**: A maximum of two work visits are allowed per patient. However, in extenuating circumstances, further motivation may be made to the Compensation Fund. Item 66323 cannot be charged with item 66211 or 66136.	40	**561.91**
66325	Reports - To be used only when reporting on work assessments. Use once per claim only	22.14	**311.02**
66327	Work hardening. Must include a graded return to work plan. Refer to Rule 020.	80	**1123.82**

7	**Procedures required to promote treatment**		
Code	**Code Description**	**Units**	**Rand**
66401	Workplace assesment (Recommendation as regards to assistive device and environmental adaptations.) Item 66401 can only be charged together with item 66211, 66321, 66323 and 66327.	15	**210.72**
8.	**Designing and constructing a custom made adaptation or assistive device, splint or simple pressure garment for treatment in task - centered activity (Specify the adaptation, device, splint or pressure garment)**		
Code	**Code Description**	**Units**	**Rand**
66403	On level one	12	**168.57**
66405	On level two	24	**337.15**
66407	On level three	36	**505.72**
66409	On level four	48	**674.29**
66411	On level five	60	**842.86**
66413	On level six	72	**1011.44**
66415	Designing and constructing a static orthosis	60	**842.86**
66417	Designing and constructing a dynamic orthosis	120	**1685.73**
9.	**Designing and Making pressure garment**		
Code	**Code Description**	**Units**	**Rand**
66419	Per limb	60	**842.86**
66421	Face (chin strap only)	45	**632.15**
66423	Face (full face mask)	60	**842.86**
66425	Trunk	90	**1264.30**
66427	Per hand	90	**1264.30**
	The whole body or part thereof will be the subtotal of the parts for the first garment and 75% of the fee for any additional garments on the same pattern.		
66431	Planning and preparation indepth home programme on a monthly basis	90	**1264.30**

	List of splints and pressure garments exempted from NAPPI codes	2025
Annexure A		
MODIFIER 0009 - Material Cost for Splints (Vat Exclusive)		
Code	**Code Description**	**Rand**
66701	Static finger extension/flexion splint	53.4
66702	Dynamic finger extension/flexion	53.4
66703	Buddy strap	52.06
66704	DIP/PIP flexion strap	60.39
66705	MP, PIP, DIP flexion strap	67.13
66706	Hand based static finger extension/flexion	265.85
66707	Hand based static thumb extension/ flexion/ opposition/ abduction	265.85
66708	Hand based dynamic finger flexion / extension	371.97
66709	Hand based dynamic thumb flexion/ extension/ opposition/ abduction	371.97
66710	Static wrist extension/ flexion	399.23
66711	Dynamic wrist extension/ flexion	399.23
66712	Flexion glove	509.42
66713	Forearm based dynamic finger flexion/ extension	637.6
66714	Forearm based dorsal protection	743.04
66715	Forearm based volar resting	743.04
66716	Static elbow extension/ flexion	885.44
66718	Shoulder abduction splint	1416.68
66719	Static rigid neck splint	761.75
66720	Static soft neck splint/brace	248.06
66721	Static knee extension	1415.33
66722	Static foot dorsiflexion	1658.68
Annexure B		
MODIFIER 0009 - Material Cost for Pressure Garments		
Code	**Code Description**	**Rand**
66801	Glove to wrist	115.61
66802	Glove to elbow	269.04
66803	Gauntlet (Glove with palm and thumb only)	115.61
66804	Sleeve: Upper/forearm	153.43
66805	Sleeve: full	230.72
66807	Sleeveless vest	554.7
66808	Upper leg	276.67
66809	Lower leg	184.3
66812	Briefs	460.98
66815	Chin strap	193.09
66816	Full face mask	369.73
66818	Finger sock	25.5

ANNEXURE C: FIRST REHABILITATION / AUTHORISATION REPORT

1. PRE- AUTHORISATION REQUEST FORM			
Please indicate your request type with an X:			
First rehabilitation report		**Extension of treatment period required**	
Clinical vocational rehabilitation intervention		**Amendment to treatment codes required**	
Additional treatment sessions required			
INJURED EMPLOYEE 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 pre-authorisation request:	**YES**	**NO**	

SUPPORTING DOCUMENTS ATTACHED TO PRE-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:	
REHABILITATION PLAN	
A. 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 REHABILITATION REPORT)

SERVICE PROVIDER DETAILS	
Name:	
Practice Number:	
Date of initial consultation:	
Date of pre-authorisation request:	
Telephone Number:	
Email address:	
Signature:	

ANNEXURE D: REHABILITATION MONTHLY/INTERIM REHAB REPORT

INJURED EMPLOYEE DETAILS		
Name and Surname of Employee:		
Identity Number:	**Address:**	
Contact number:	**Postal Code:**	
Next of kin:		
Name of Employer:		
Contact number:		
Address:		
Date of Accident:	**Postal Code:**	
Diagnosis/ ICD 10 codes		
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. ROM, oedema, muscle strength, hand function)		
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. a. Has the employee returned to work? (please circle where applicable)	**Yes**	**No**
b. If yes, from what date have they been fit for normal / light work? (Please circle where applicable)	**Date:**	
c. If no, are there prospects of the client returning to work? (Please circle where applicable)	**Yes**	**No**

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: Rehabilitation progress reports must be submitted on a monthly basis and attached to the submitted accounts.	

ANNEXURE E: FINAL REHABILITATION REPORT

INJURED EMPLOYEE DETAILS		
Name and Surname of Employee:	**Address:**	
Identity Number:		
Contact number:		
Postal Code:		
EMPLOYER DETAILS		
Name of Employer:		
Contact number:		
Address:		
Postal Code:		
Date of Accident:		
Diagnosis/ ICD 10 codes:		
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. ROM, oedema, muscle strength, hand function):		
3. Did the patient undergo surgical procedures in this time? Dates and type of surgery		
4. a. From what date has the employee returned to work? (please circle where applicable)	**Yes**	**No**
b. If yes, from what date have they been fit for his/her normal/ light work? (Please circle where applicable)		
c. If no, are there prospects of the client returning to work? (Circle where applicable)	**Yes**	**No**
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 (R.O.M., if any, must be indicated in degrees at each specific joint)	
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: Rehabilitation progress reports must be submitted on a monthly basis and attached to the submitted accounts.	

ANNEXURE F

OCCUPATIONAL THERAPY REQUEST FOR WHEELCHAIRS & ASSISTIVE DEVICES

INJURED EMPLOYEE DETAILS			
Claim number		**Identity number**	
Name		**Contact number**	
Address		**Postal code**	
Date of accident			
EMPLOYER DETAILS			
Name of employer		**Contact number**	
Address		**Postal code**	
MOTIVATION			
1. Diagnosis:			
2. Describe patient's current symptoms and functional status:			
3. Equipment currently being used			
4. Equipment recommended			
5. Motivation for equipment (with reference to home / work environment)			
6. Quotes attached (minimum of three)			
Signature of occupational therapist			
Practice number		**Date**	

FOR WHEELCHAIR REQUESTED, THIS FORM MUST BE SUBMITTED TOGETHER WITH THE COMPLETED WHEELCHAIR ASSESSMENT AND PRESCRIPTION FORM IN THE ORTHOTICS GAZETTE

ANNEXURE G

WORK SITE ASSESSMENT REPORT

Employee Information		
Employee Name:		
Identity Number:		
Contact details:		
Diagnosis:		
Date of injury:		
Date of Report:		
Company Information		
Name of company:		
Contact Person:		
Address:		
Telephone number:		
Email address:		
Occupational health Doctor and / or Nurse name and contact number:		
Employer representative:		
Designation:		
Work Status		
Current work status:	• Signed off on IOD leave	
	• Working in accommodated duties	
	• Able to complete own job but a number of difficulties noted	
	• Completing own occupation	
	• Working accommodated hours	
	• Signed off on other leave	
	• Fit for work, but not returned yet	
	• Working in a temporary alternative occupation	
	• Working in a permanent alternative occupation	
Date returned to work, if currently working		
Current job information:		
Job title:		

Normal safety equipment utilised:		
The position is:	Permanent	
	Contract	
Normal work hours:		
Overtime hours:		
Job Analysis		
The position is defined according to the D.O.T as:	Sedentary	
	Light	
	Medium	
	Heavy	
	Very heavy	
Job description (A brief overview of the requirements of the job)		

Job tasks	As described by the employee	Reported difficulties – if currently working
1		
2		
3		
4		
5		
6		

Employer comments:

Inherent physical demands of the job:		
Return to work plan:		
Given the employee's current physical abilities, it is considered that they are currently:	• Able to complete their own job	
	• Complete the job, however with difficulty or lower efficiency / productivity	
	• Able to work, but requires accommodated duties	
	• Able to work, but requires accommodated hours	
	• Is not currently able to complete the job	
Anticipated Return-to-Work date:		
Agreed accommodations		
Duties agreed:		
Work days:		
Work hours:		
Breaks required:		
Tasks to avoid:		
The employee did / did not trial the agreed accommodations during the work visit:		
Additional comments:		

INHERENT JOB ANALYSIS

(Denotes if the item was assessed during the work site visit)	General observations (Time / Repetitions / Loads / Distance)	Frequency over the work day			Job Tasks (state number as listed above)
		Occasional (< 1/3)	Frequent (1/3 < 2/3)	Constant (>2/3)	
Work positions					
Standing					
Sitting					
Squatting					
Kneeling					
Crouching					
Trunk rotation					
Mobility					
Walking (even / uneven terrain					
Crawling					
Climbing a ladder					
Climbing stairs					
Endurance					
Reaching					
Overhead reaching					
Forward reaching					
Reaching to left					
Reaching to right					
Lifting					
Floor to knuckle					
Knuckle to shoulder					
Shoulder to overhead					
Carrying					
Bilateral					
Unilateral					
Pushing / Pulling					
Pushing					
Pulling					

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