CONTENTS

No.		Page No.	Gazette No.
	GENERAL NOTICE		
Labour, Department of			
General Notice			
857	Compensation for Occupational Injuries and Diseases Act (130/1993): Scale of fees for Physiotherapists ..	3	30084

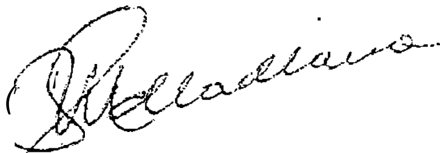
GENERAL NOTICE

NOTICE 857 OF 2007

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 (ACT NO. 130 OF 1993), as amended

1. I, Membathisi Mphurnzi Shepherd Mdladlana, Minister of Labour, hereby give notice that, after consultation with the Compensation Board and acting under the powers vested in me by Section 97 of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No. 130 of 1993), I prescribe the Scale of "Fees for Medical Aid" payable under section 76, inclusive of the General Rules applicable thereto, appearing in the Schedule to this notice, with effect from 1 April 2007.

2. The fees appearing in the Schedule are applicable in respect of services rendered with retrospective effect as from 1 April 2007 and Exclude VAT.



M M S MDLADLANA
MINISTER OF LABOUR
27/06/07

GENERAL INFORMATION / *ALGEMENE INLIGTING.*

(i) THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER.

The employee is permitted to choose freely his own service provider e.g. doctor, pharmacy, physiotherapist, hospital, etc. and no interference with this privilege is permitted as long as it is exercised reasonably and without prejudice to the employee himself or the Compensation Fund. The only exceptions to this rule are those cases where employers, with the Compensation Commissioner's approval, provide their own medical aid facilities in total, i.e, including hospital, nursing and other services-section 78 of the Act refers.

In terms of section 42 either the Compensation Commissioner or an employer may send the injured employee to another doctor chosen by him (Compensation Commissioner or employer) for a special examination and report. Special fees are payable for this service. This examination and report is usually done only by specialists.

In the event of a change of doctors attending a case, the first doctor in attendance will, except where the case is handed over to a specialist, be regarded as the principal. To avoid disputes, doctors should refrain from treating a case already under treatment without first discussing it with the first doctor. As a general rule, changes of doctor are not favoured, unless there are sufficient reasons therefore.

According to the National Health Act no 61 of 2003 : section 5, a health care provider may not refuse a person emergency medical treatment. Any provider should not however, ask the Compensation Commissioner to authorise such treatment before the claim has been admitted as falling within the scope of the COID Act. Pre authorisation for treatment is not applicable and no medical expenses will be considered or approved if liability for the claim against the Fund has not been accepted.

It should be remembered that an employee seeks medical advice at his own risk. If, therefore, an employee represents to his medical service provider that he is a Compensation for Occupational injuries and Diseases Act case and yet fails to claim the benefits of the Act, leaving the Compensation Commissioner, or his employer, in ignorance of any possible grounds for a claim, the insurance fund concerned cannot accept any responsibility for any medical expenses incurred if the claim is not reported in the prescribed manner. The Compensation Commissioner can also have reason not to accept the claim lodged against the Fund. In such circumstances the employee would be in the same position as any other member of the public as regards payment of his medical expenses.

Please note that as from 1 January 2004 a certified copy of an employee's identity document will be required in order to register a claim 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 you/the employer to attach a certified copy of the employee's identity document. Furthermore, all supporting documentation sent to this office must reflect the identity number as well. If it is not reflected, the documents will not be processed but will be returned to the sender to add the ID number.

The amounts published in the tariff for COIDA for medical services are calculated without VAT. The only exclusion is the "per diem" tariff for Private Hospitals, that includes VAT. The account for services rendered will be assessed and calculated without VAT. If VAT is applicable and a VAT registration number is indicated, it will be calculated and added to the payment without being rounded off.Also please note that there are VAT exempted codes in the private ambulance tariff structure.

(i) DIE WERKNEMER EN DIE MEDIESE DIENSVERSKAFFER

Die werknemer het 'n vrye keuse van diensverskaffer by. Dokter, apteek, fisioterapeut, hospitaal ens. en geen inmenging met hierdie voorreg word toegelaat solank dit redelik en sonder nadeel vir die werknemer self of die Vergoedingsfonds uitgeoefen word nie. Die enigste uitsonderings op hierdie reël is in daardie gevalle waar die werkgewers met die goedkeuring van die Vergoedingskommissaris hul eie geneeskundige dienste in die geheel voorsien, d.i. insluitende hospitaal- verplegings- en ander dienste-artikel 78 van die Wet verwys.

Kragtens die bepalings van artikel 42 mag die Vergoedingskommissaris of die werkgewer na gelang van die geval, 'n beseerde werknemer na 'n ander geneesheer deur hom (Vergoedingskommissaris of werkgewer) aangewys, stuur vir In spesiale ondersoek en verslag. Spesiale gelde is betaalbaar vir hierdie dienste. Hierdie ondersoek word feitlik uitsluitlik deur spesialiste gedoen.

In die geval van verandering van geneeshere wat 'n geval behandel, sal die eerste geneesheer wat behandeling toegedien het, behalwe waar die geval aan 'n spesialis oorhandig is, as die lasgewer beskou word. Ten einde geskille te voorkom, moet geneeshere hul daarvan weerhou om 'n geval wat reeds onder behandellng is te behandel sender om dit eers met die eerste geneesheer te bespreek. Oor die algemeen word veranderings van geneeshere, tensy voldoende redes daarvoor bestaan, nie aangemoedig nie.

Volgens die Nationale Gesondheidswet no 61 van 2033 : seksie 5, mag 'n gesondheidswerker of diensverskaffer nie weier om noodbehandeling te verskaf nie. Hy moet egter nie die Vergoedingskommissaris vra om sulke behandeling goed te keur alvorens aanspreeklikheid vir die eis kragtens die Wet aanvaar is nie. Vooraf goedkeuring vir behandeling is nie van toepassing nie en geen mediese onkoste sal oorweeg word as die eis teen die Fonds nie anvaar is nie,

Dit moet in gedagte gehou word dat 'n werknemer geneeskundige behandeling op sy eie risiko soek. As In werknemer dus aan 'n geneesheer voorgee dat hy In geval is onder die Wet op Vergoeding vir Beroepsbeserings en Siektes en tog versuim om die voordele van die Wet te eis deur die Vergoedingskommissaris of sy werkgewer in die duister te laat van enige moontlike gronde vir In eis, kan die betrokke versekeringsfonds geen aanspreeklikheid aanvaar vir geneeskundige onkoste wat aangegaan is nie as die besering nie aangemeld is op die voorgeskrewe wyse nie. Die Vergoedingskommissaris kan ook rede he om nie die eis teen die Fonds te aanvaar nie. Onder sulke omstaridighede sou die werknemer in dieselfde posisie verkeer as enige lid van die publiek-wat betaling van sy geneeskundige onkoste betref.

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

Die bedrae gepubliseer in die tarief vir COIDA is BTW uitgesluit. Die enigste uitsondering is die "per diem" tarief vir Privaat Hospitale, wat BTW insluit. Die rekening vir dienste gelewer word aangeslaan en bereken sonder BTW. Indien BTW van toepassing is en 'n BTW registrasie nommer aangedui is, word dit bereken en by die betalingsbedrag gevoeg sonder om afgerond te word. Neem asseblief ook kennis dat daar kodes in die privaat ambulans struktuur is waarop BTW nie betaalbaar is me.

CLAIMS WITH THE COMPENSATION FUND ARE PROCESSED AS FOLLOWS.
ElSE TEEN DIE VERGOEDlNGSFONDS WORD HANTEER SOOS VOLG:

'I. Allocation of a clam number by the Fund, does not constitute that liability has been accepted, but that the injury on duty has been reported to the Compensation Commissioner. New claims are registered by the Commissioner and the employer is notified of the claim number allocated to the claim. Enquiries for claim numbers should be directed to the employer and not to the Commissioner. The employer will be able to give you the claim number for the patient as well as indicate whether the Compensation Commissioner accepted the claim as a COIDA case • *Nuwe eise word geopen deur die Kommissaris en die werkgewer word in kennis gestel van die eisnommer. Navrae vir eisnommers moet aan die werkgewer gerig word en nie aan die Kommissaris nie. Die werkgewer kan die eisnommer verskafen ook aandui of die Kommissaris die eis teen die Fonds aanvaar het ofnie*

2. If the claim is accepted as a COIDA claim, reasonable medical expenses will be paid by the Compensation Commissioner. *As die eis teen die Fonds aanvaar word, word redelike mediese koste betaal deur die Vergoedings Kommissaris.*

3. If the claim is rejected (repudiated), services will not be paid by the Compensation Commissioner. The employer and the employee are informed of this decision. The injured employee will be liable for payment. • *As die eis teen die Fonds afgekeur word (gerepudieer), word dienste nie deur die Vergoedings Kommissaris betaal nie. Die betrokke partye word in kennis gestel van die besluit, ingesluit die diensverskaffers. Die beseerde werknemer is dan aanspreeklik vir die rekening.*

4. If no decision can be made due to inadequate/lack of information, the outstanding information is requested and upon receipt, the claim will again be adjudicated. Depending on the outcome, the accounts from the service provider, will be handled as set out in 2 and 3. Please note that there are cIlaims for which a decision might never be made due to inadequate/lack of forthcoming information • *Indien geen besluit geneem kan word nie, weens 'n gebrekaan inligting, word die uitstaande inligting aangevra. Met ontvangs word die eis heroorweeg. Ajhangende van die uitslag, word die rekening hanteer soos uiteengesit in nommer I en 2. Ongelukkig is daar eise waar 'n besluit nooit geheem kan word nie aangesien die uitstaande inligting nie verskafword nie.*

BILLING PROCEDURE. EIS PROSEDURE:

1. The first account for services rendered to the injured employee (INCLUDING the First medical report) must be submitted to the employer who will collate all the documents (from other service providers etc.) and submit them to the Compensation Commissioner. *Die eerste rekening (INSLUITEND die Eerste mediese verslag) vir diens gelewer aan die beseerde werknemer, moet aan die werkgewer gestuur word, wat die eise (van ander diensverskqffers ens.) bymekaar sal sit en dit aanstuur na die Vergoedingskommissaris.*

2. Subsequent accounts must be submitted or posted to the closest Labour Centre. It is important that all requirements for the submission of accounts, including supporting information, are met. • Daaropvolgende rekeninge moet ingedien of gepos word na die naaste Arbeids kantoor. Dit is belangrik dat al die voorskrifte vir indien van rekeninge gevolg word, ingesluit die voorsien van stawende dokumentasie.

3. If accounts are still outstanding after 60 days following submission service providers should complete an enquiry form, W.CL 20, and submit it ONCE to the Labour Centre. All relevant details about the Labour Centres are available on the website www.labour.gov.za • *Indien die rekening nog uitstaande is na 60 dae na indiening an ontvangserkenning deur die Vergoedingskommissaris, moet die diensverskafJer 'n navraag vorm, W. CL 20 voltooi en EENMALIG indien na die Kommissaris.*

4. If the account is partially paid with no reason therefore indicated on the remittance advice, a duplicate account with the unpaid services clearly indicated must be submitted to the Labour Centre, accompanied by a WCI 20 form. (*see website for example). All relevant details about the Labour Centres are available on the website www.labour.gov.za • *Indien 'n rekening gedeeltelik betaal* is *met geen rede voorsien op die betaaladvies nie, kan 'n duplikaatrekening met die kortbetaling duidelik aangedui, vergesel van 'n WCl20 vorm ingedien word (*sien webblad vir voorbeeld van vorm).*

5. Information NOT to be reflected on the account: Details of the employee's medical aid and the practice number of the referring practitioner. *Inligting wat NIE aangedui moet word op die rekening nie: Besonderhede van die werknemer se mediese fonds en die verwysende geneesheer se praktyknommer.*

6. Service provider should not generate • *Diensverskaffer moenie die volgende genereer:*

   a. Multiple accounts for services rendered on the same date i.e. one account for medication and a second account for other services • *Meer as een rekening vir dienste gelewer op dieseifde datum, bv. Medikasie op een rekening en ander dienste op 'n tweede rekening.*
   b. Accumulative accounts - submit a separate account for every month • *Aaneenlopenderekeninge: aparte rekeninge per maand word verkies.*
   c. Accounts on the old documents (W.CL 4/5/5F) A *New First Medical Report (W.CL 4) and Progress/Final Report (W.CL 5/5F) forms are available. The old forms combined with the account (W.CLl1), were replaced. Accounts on the old

medical reports will not be entertained • *Rekeninge op die ou voorgeskrewe dokumente van die Vergoedingskommissaris. 'n *Nuwe Eerste mediese verslag (W.CL4) en VorderinglFinale verslag (W.CL5) is beskikbaar. Die vorige vorms gekombineer met die rekening (W.CLll) is vervang. Rekeninge op die ou vorms is nie aanvaarbaar nie.*

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

* *Voorbeelde van die nuwe vorms (W.CL 4/5/5F) is beskikbaar op die webblad www.labour.gov.za*

TARIFF OF FEES IN RESPECT OF PHYSIOTHERAPY SERVICES FROM 1 APRIL 2007

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

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

003. If there is no active physiotherapy treatment for a period of 3 calendar months, treatment will be deemed to have ended. Subsequent physiotherapy treatment will require a new referral letter and new treatment plan. For treatment beyond 20 service dates, a rehabilitation progress report (included in tariff) must be submitted to the Compensation Fund.

004. In the case of prolonged and costly treatments, these should only be embarked upon after negotiations with the treating medical practitioner and the Compensation Commissioner.

005. After a series of 20 service dates for the same condition, the physiotherapist must refer the employee back to the medical practitioner and report to him/her with a rehabilitation progress report, the progress already made. If further physiotherapy treatment is required the medical practitioner must submit a progress report and the rehabilitation progress report to the Compensation Commissioner indicating the necessity for further treatment and the number of further treatments required. The rehabilitation progress report (attached to tariff) must be submitted to the Fund at the start of

treatment and thereafter every 20 service dates. Without such a report payment for treatments in excess of 20 service dates shall not be considered.

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

For the purpose of this rule:
Emergency treatment means a 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. Routine physiotherapy does not qualify as emergency treatment.

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

008. When a COID patient is referred for physiotherapy treatment after a surgical procedure, a new set of 20 service dates will take effect.

009. This applies to AM and PM treatments, which should be specified and medically motivated for on the progress rehabilitation report.

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

012. Applies to VAT vendors only i.e. only when VAT is to be added to the tariff. The account for services rendered will be assessed and calculated without Vat. If VAT is applicable; it will be calculated and added to the payment amount.

013. Where a physiotherapist was called out from residence or rooms to a COID patient's home or hospital, travelling fees can be charged for the travelling more than 16km in total. If more than one employee would be attended to during the course of a trip, the full travelling expenses must be divided pro rata between the relevant employees. A physiotherapist is not entitled to charge for any travelling expenses or travelling time to his/her rooms.

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

015. The services of a physiotherapist shall be available only on referral by the treating medical practitioner. Where a physiotherapy letterhead is used as a referral letter, it must have the medical practitioner's signature, date and stamp. The current referral letter to cover any physiotherapy services provided should be submitted to the Compensation Commissioner.

MODIFIERS GOVERNING THE TARIFF

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

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

0013 R5,OO per km for each kilometre in excess of 16 kilometres total travelled in own car e.g. 19km total=3xR5,OO=R15,00 (No travelling time claimed for)

0014. Treatment in a nursing facility.

PHYSIOTHERAPY TARIFF OF FEES 2007

Please note: No other treatment modalities may be charged in conjunction to the codes below except for evaluation and visiting codes. Simple evaluation cannot be charged simultaneously with a complex evaluation/re-assessment.

Code	Service type	Service description	Tariff
72701	Evaluation level 1 (to be fully documented)	Applies to simple evaluation once at first visit only. It should not be used for each so called "condition". A treatment plan /rehabilitation progress report must be submitted at the start of treatment.	R 137.40
72702	Complex evaluation (to be fully documented)	Complex evaluation/counselling once at first visit only. Applies to multiple complex injuries only. It should not be used for each so called "condition". A treatment plan /rehabilitation progress report must be submitted at the start of treatment.	R 206.00
72703	Re-assessment	Complete re-assessment or counselling, during the course of treatment. This code also to be used for one physical performance test that must be fully documented and report provided to the CF.	R 68.50
72901	Treatment at nursing home	Relevant fee plus (to be charged only once per day and not with every hospital visit)	R 50.20
72305	Bed program	Bed exercises/passive movements	R 50.20
72509	Extra treatment time	Should be medically motivated for e.g. complicating condition. This code can only be claimed once per treatment session.	R 76.30
72903	Domiciliary treatments	Apply only when medically motivated: relevant fee plus.	R 91.40
72925	Level 1 chest pathology	Applies to simple chest conditions/ injuries. Multiple treatment techniques to be used.	R 225.00

Code	Service type	Service description	Tariff
72926	Level 2 chest pathology	Applies to complex chest conditions /injuries which require undivided attention of the physiotherapist only. Multiple treatment techniques to be used.	R 371.80
72921	Simple spinal treatment	Applies to simple spinal injuries /conditions. Multiple treatment techniques to be used.	R 330.50
72923	Complex spinal treatment	Applies to complex conditions/injuries to the vertebral column only. Multiple treatment techniques to be used.	R 477.30
72928	Simple soft tissue injuries/ peripheral joints treatment	Applies to simple soft tissue/peripheral joint's injuries/conditions. Multiple treatment techniques to be used.	R 330.50
72927	Complex soft tissue injuries/ peripheral joints treatment	Applies to multiple severe/complex injuries only. Multiple treatment techniques to be used.	R 431.60
72501	Rehabilitation	Rehabilitation first 30 minutes, where the pathology requires the undivided attention of the physiotherapist	R 101.10
72503	Rehabilitation central Nervous system	Also includes spinal rehab (cannot be charged for bed exercises/passive movements only)	R 477.30
72939	Cost of material	Single items below R 1572.00 (Vat EXCLUDED) May be charged for at a cost price plus 20% storage and handling. Invoice must be attached Cost of materials does not cover consumables. See the attached Annexure A for consumables and Annexure B for equipment and or appliances considered reasonable to be used with code 72939.	

ANNEXURE A

LIST OF CONSUMABLES

To be used with code 72939

Service providers may add on 20%, for storage and handling.

NAME OF PRODUCT	**UNIT**	**APPROX UNIT PRICE** (excl VAT)
Tubigrip (A & 8 white)	1	92.11
Self adhesive disposable electrodes (one set per		
Employee is payable)	1	36.84
SPORTS:		
TAPING/Strapping(type & quantity must be specified)		
Elastoplast 75mm x 4.5	1	78.95
Coverrol	1	58.77
Leukotape	1	78.95
Magic grip spray	1	57.02
Fixomull	1	65.79
Leukoban 50-75mm x 4.5m	1	30.70
Other		
Incontinence electrodes for pathway EMG	1	175.44
EMG flat electrodes	1	14.91
(should be medically justified)		

ANNEXURE B

LIST OF Equipment/appliances

To be used with code 72939

***Services providers may add on 20%, for storage and handling.
Equipment not payable if already supplied by Orthotic and Prosthetic Practitioner for the same employee.

NAME OF PRODUCT	UNIT	APPROX UNIT PRICE (excl VAT)
Hot/cold packs	1	35.09
Braces		
Cervical collar	1	35.09
Lumbar brace	1	206.14
Standard heel cups	pair	52.63
Cliniband	1	28.07
Fitband 5.5cm	1	71.05
Fitband 30cm	1	249.12
Peak flow meter	1	164.04
Peak flow meter	2	1.75

Claim Number: --------------------------

REHABILITATION PROGRESS REPORT

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASE ACT,1993
(Act No. 130 of 1993)

Names and Surname of Employee ______________________________

Identity Number Address _

________________________Postal Code _

Name of Employer _

Address _

______________________________Postal Code, _

Date of Accident, _

---

1. Date of first treatment Provider who provided first treatment ______
2. Initial clinical presentation and functional status, _
3. Name of referring medical practitioner Date of referral __
4. Describe patient's current symptoms and functional status _
5. Are there any complicating factors that may prolong rehab or delay recovery (specify)? _
6. Overall Goal of treatment: _
7. Number of sessions already delivered. Progress achieved. _

Claim Number : ---------------------------

8. Number of sessions required Treatment plan for proposed treatment sessions, _

9. From what date has the employee been fit for hislher normal work? _

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

II. If so, describe in detail any present permanent anatomical defect and/or impairment offunction 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 rehabilitation service provider _

Name(Printed) Date(Important) __

Address _

Practice number _

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