GENERAL NOTICES • ALGEMENE KENNISGEWINGS

DEPARTMENT OF EMPLOYMENT AND LABOUR

NOTICE 180 OF 2021

PHYSIOTHERAPIST GAZETTE 2021.

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

(ACT 130 OF 1993 as amended by Act 61 of 1997)

NOTICE ON ANNUAL INCREASE IN MEDICAL TARIFFS PAYABLE UNDER SECTION 76 OF THE COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT AS AMENDED

1.

I, Thembelani Thulas 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 2021.

2.

Medical Tariffs increase for **2021** is **5.47%**

3.

The fees appearing in the Schedule are applicable in respect of services rendered on or after **1 April 2021** and Exclude **15% Vat.**

MR TW NXESI, MP
MINISTER OF EMPLOYMENT AND LABOUR
DATE: 2021/01/25

GENERAL INFORMATION

THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

The employee is permitted to freely choose his own service provider e.g. doctor, pharmacy, physiotherapist, hospital, etc. and no interference with this privilege is permitted, as long as it is exercised reasonably and without prejudice to the employee or to the Compensation Fund. The only exception to this rule is in case where an employer, with the approval of the Compensation Fund, provides comprehensive medical aid facilities to his employees, i.e. including hospital, nursing and other services — section 78 of the Compensation for Occupational Injuries and Diseases Act refers.

In terms of section 42 of the Compensation for Occupational Injuries and Diseases Act, the Compensation Fund may refer an injured employee to a specialist medical practitioner 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 own risk. If an employee represented to a medical service provider that he is entitled to treatment in terms of the Compensation for Occupational Injuries and Diseases Act, and yet failed to inform the Compensation Commissioner or his employer of any possible grounds for a claim, the Compensation Fund cannot accept responsibility for medical expenses incurred. The Compensation Commissioner could also have reasons not to accept a claim lodged against the Compensation Fund. In such circumstances the employee would be in the same position as any other member of the public regarding payment of his medical expenses.

Please note that from 1 January 2004 a certified copy of an employee's identity document will be required in order for a claim to be registered with the Compensation Fund. If a copy of the identity document is not submitted the claim will not be registered but will be returned to the employer for attachment of a certified copy of the employee's identity document. Furthermore, all supporting documentation submitted to the Compensation Fund must reflect the identity number of the employee. If the identity number is not included such documents can not be processed but will be returned to the sender to add the ID number.

The tariff amounts published in the tariff guides to medical services rendered in terms of the Compensation for Occupational Injuries and Diseases Act do not include VAT. All accounts for services rendered will be assessed without VAT. Only if it is indicated that the service provider is registered as a VAT vendor and a VAT registration number is provided, will VAT be calculated and added to the payment, without being rounded off.

The only exception is the "per diem" tariffs for Private Hospitals that already include VAT.

Please note that there are VAT exempted codes in the private ambulance tariff structure.

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 accounts from the service provider will be dealt with as set out in 2 and 3. Please note that there are claims on which a decision might never be taken due to lack of forthcoming information.

BILLING PROCEDURE

1. All service providers should be registered on the Compensation Fund claims system in order to capture invoices and medical reports.

   1.1 Medical reports should always have a clear and detailed clinical description of injury and related ICD 10 Code.
   1.2 In a case where a surgical procedure is done, an operation report is required
   1.3 Only one medical report is required when multiple procedures are done on the same service date
   1.4 A medical report is required for every invoice submitted covering every date of service.
   1.5 Referrals to another medical service provider should be indicated on the medical report.
   1.6 Medical reports, referral letters and all necessary documents should be uploaded on the Compensation Fund claims system.

NOTE: 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.

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.
   2.3 Service providers may capture and submit medical invoices directly on the Compensation Fund system online application.

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, 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.

- 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:

a. Multiple invoices for services rendered on the same date i.e. one invoice for medication and a second invoices for other services.
b. Cumulative invoices – Submit a separate invoice for every month.

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

MINIMUM REQUIREMENTS FOR INVOICE RENDERED

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

- Name of employee and ID number
- Name of employer and registration number if available
- Compensation Fund claim number
- 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 account)
- 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 account
- It is important that all requirements for the submission of invoices are met, including supporting information, e.g:
    - All pharmacy or medication accounts 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
86	Psychologists
87	Orthotists & Prosthetists
88	Registered nurses
89	Social workers

90	Manufacturers of assisstive devices

TARIFF OF FEES IN RESPECT OF PHYSIOTHERAPY SERVICES

FROM 1 APRIL 2021

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

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

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

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

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

For the purpose of this rule:

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

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

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

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

.

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

013. Where a physiotherapist is called out from residence or rooms to an employee's home or hospital, travelling fees to be charged for travelling will be R 4.12 per kilometer from the 1st kilometer. If more than one employee is attended to during the course of a trip, the full travelling expenses must be divided pro rata between the relevant employees(the physiotherapist will claim for one trip). A physiotherapist is not entitled to charge any travelling expenses or travelling time to his / her rooms.

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

018 Information Modifier to indicate services rendered to outpatients

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

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.**

NB **Only one of the following codes can be claimed per session/consultation: 72925,72926,72921,72923,72928,72927,72501 and 72503**

MODIFIERS GOVERNING THE TARIFF

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

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

0013 R4.12 per km for each kilometre

0014. Treatment in a nursing facility.

PHYSIOTHERAPY TARIFF OF FEES AS FROM 1 APRIL 2021

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

Code	Service type	Service description	RandValue
72701	Evaluation level 1 (to be fully documented)	Applies to simple evaluation **once** at first visit only. It must not be used for each condition. A treatment plan / rehabilitation progress report must be submitted at the initiation of treatment.	**293.97**
72702	Complex evaluation (to be fully documented)	Complex evaluation **once** at first visit only. Applies to complex evaluation once at first visit only. Applies to complex injuries only. It must not be used for each condition. A treatment plan / rehabilitation progress report describing what makes the evaluation complex, must be submitted at the initiation of treatment.	**440.55**
72703	Re-assessment	Complete re-assessment or one physical performance test during the course of treatment. This should be fully documented and a rehabilitation progress report provided to the CF. 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.	**146.60**
72901	Treatment at nursing home	Relevant fee plus (to be charged only once per day and not with every hospital visit)	**107.42**
72305	Very Simple treatment	Simple treatment for one condition/injury of one treatment technique	**107.42**
72509	Extra treatment time	There should be a clear indication and motivation and Should be medically motivated for e.g. complicated condition. This code can only be claimed once per treatment session.	**163.28**
72903	Domiciliary treatments	Apply only when medically motivated: relevant fee plus.	**195.46**
72925	Level 1 chest pathology	Applies to simple chest conditions / injuries. Multiple treatment techniques to be used.	**481.27**
72926	Level 2 chest pathology	Applies only to complex chest conditions / injuries that require undivided attention of the physiotherapist. Multiple treatment techniques to be used.	**795.19**
72921	Simple spinal treatment	Applies to simple spinal injuries / conditions. Multiple treatment techniques to be used.	**706.78**
72923	Complex spinal treatment	Applies to complex spinal injuries/conditions. Multiple treatment techniques to be used. Rehabilitation reports must clearly indicate the reasons for choosing complex as apposed to simple.	**1 020.90**
72928	Simple soft tissue / peripheral joint injuries or other general treatment	Apply to all soft tissue / peripheral injuries or other general treatment.	**706.78**

72927	Complex soft tissue / peripheral joint injuries or other general treatment	Applies to complex soft tissue/peripheral joint injuries/conditions. Multiple treatment techniques to be used. Rehabilitation reports must clearly indicate the reasons for choosing complex as opposed to simple.	**923.17**
72501	Rehabilitation	Rehabilitation first 30 minutes, where the pathology requires the undivided attention of the physiotherapist	**510.36**
72503	Rehabilitation centralnervous system	Also includes spinal rehabilitation (cannot be charged for bed exercises / passive movements only)	**1 020.90**
72939	Cost of material	Single items below R 1733.90 (VAT excl)may be charged for at cost price plus 20% storage and handling fees. The invoice must be attached to the account.	
		Cost of materials does not cover consumables	
		See the attached **Annexure A** for consumables and **Annexure B** for equipment and or appliances that are considered reasonable to be used with code 72939	

ANNEXURE A **LIST IF CONSUMABLES** **To be used with code 72939** **Service provider may add on 20% for storage and handling**		
NAME OF PRODUCT	**UNIT**	**APPROX UNIT** **PRICE(excl VAT)**
Tubigrip (A & B white) 100 cm	1	23.50
Self adhesive disposable electrodes (one per employee as payable)	1	74.65
Sports		
Taping / Strapping (type &quality must be specific)		
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 electrodes	1	30.15
should be medically justified		

ANNEXURE B **List of equipment / appliances to be used with code 72939.** **Service provider may add on 20% for storage and handling.** **Equipment not payable if the same were already supplied to same employee by an Orthotist Prosthetist.**		
NAME OF PRODUCT	**UNIT**	**APPROX UNIT PRICE (excl VAT)**
Hot/ cold packs	1	255.00
Braces		
Cervical collar	1	132.00
Lumbar brace	1	545.00
Standard heel cups	Pair	165.00
Cliniband	1	56.82
Fit band 5.5cm (100cm)	1	14.41
Fit band 30cm (100cm)	1	50.52
Peak flow meter	1	332.59
Peak flow meter disposable mouthpiece	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:**_____

labour
Department:
Labour
REPUBLIC OF SOUTH AFRICA

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	Employee sumame	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)	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