GENERAL NOTICES • ALGEMENE KENNISGEWINGS

DEPARTMENT OF EMPLOYMENT AND LABOUR

GENERAL NOTICE 1707 OF 2023

OPTOMETRY GAZETTE 2023

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Compensation Fund, Delta Heights Building 167 Thabo Sehume Street, Pretoria 0001
Tel: 0860 105 350 | Email address: cfcallCentre@labour.gov.za www.labour.gov.za

DEPARTMENT OF LABOUR

NOTICE: **DATE:**

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASSES ACT, 1993 (ACT NO.130 OF 1993), AS AMENDED

ANNUAL INCREASE IN MEDICAL TARIFFS FOR MEDICAL SERVICES PROVIDERS.

1. I, Thembelani Waltermade Nxesi, Minister of Employment 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 2023.

2. Medical Tariffs increase for 2023 is 4%

3. The fees appearing in the Schedule are applicable in respect of services rendered on or after 1 April 2023 and Exclude 15% Vat.

.....

Mr TW NXESI, MP

MINISTER OF EMPLOYMENT AND LABOUR

24/01/2023

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GENERAL INFORMATION ABOUT THE COMPENSATION FUND AND ITS MEDICAL SERVICES BENEFITS DIRECTORATE

THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

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):

- An employee as defined in the COID Act of 1993, is at liberty to choose their preferred medical service provider and no interference with this is permitted, as long as it is exercised reasonably and without prejudice to the employee or 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 COID Act of 1993, 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 COID Act of 1993, no amount in respect of medical expenses shall be recoverable from the employee.
- In the event of a change of a medical practitioner 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.
- 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 principal treating doctor. As a general rule, changes of doctor are not favoured by the Compensation Fund, unless sufficient reasons exist for such a change.
- 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 liability for the claim is 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 their own risk. If such an employee presents themselves to a medical practitioner as being entitled to treatment in terms of the COID Act of 1993, 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.
- The Compensation Fund could also 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 his medical expenses.

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- Proof of identity is required in the form of a copy of a South African 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.
- All supporting documentation submitted to the Compensation Fund must reflect the identity and claim number of the employee.
- The completion of medical reports cannot be claimed separately as they are inclusive in all medical tariffs.
- The tariff amounts published in the gazette guides for medical services rendered in terms of the COID Act do not include VAT. All invoices for services will therefore be assessed without VAT.
- VAT will therefore be calculated and applied without rounding off to invoices for service providers that have confirmed their VAT vendor status with the Compensation Fund by the submission of their VAT registration number.

POPI 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, unauthorized access and damage to information by unauthorized parties.

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OVERVIEW OF CLAIMS PROCESS WITHIN THE COMPENSATION FUND

All claims lodged in the prescribed manner with the Compensation Fund follow the process outlined below:

1. New claims are registered by the Employers with the Compensation Fund and the employer, if registered as a user on the online processing system is able to view claim details like the claim number allocated, and the progress of the claim online.
    a. 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 with the Compensation Commissioner.
    b. Any enquiries related to a claim should be directed to the employer and or the nearest Labour Centre
2. If 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 injured/diseased employee's. Reasonable medical expense shall be paid in line with its approved Tariffs and Billing rules and procedures, published annually in Government Gazettes.
3. If a claim is repudiated in terms of the COID Act, medical expenses for services rendered will not be paid by the Compensation Fund. The employer and the employee will be informed of this decision and the injured employee will be liable for payment.
4. In the case sufficient information pertaining to a claim is unavailable after registration thereof, the status of the claim will be rejected until the outstanding information is submitted and liability of the claim can be determined. Depending on the outcome, the invoices from the service provider will be dealt with as set out in 2 and 3. Please note that there are claims on which a decision might never be taken due to the non-submission of outstanding information.
5. The Compensation Fund will only pay reasonable medical expenses for treatment of the condition that liability has been accepted and will not pay for any other unrelated treatment.

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MEDICAL SERVICE PROVIDERS REGISTRATION REQUIREMENTS WITH THE COMPENSATION FUND

The Compensation Fund requires that any Medical Service Provider who seeks to treat patients in terms of the COID Act must register their details including their banking details with the Compensation Fund. They must thereafter register as a user of the online processing system.

The steps that are to be followed are detailed hereunder:

REGISTERING WITH THE COMPENSATION FUND AS A MEDICAL SERVICE PROVIDER TREATING INJURED/DISEASED EMPLOYEES

1. Copies of the following documents must be submitted:
    a. A certified identity document of the practitioner
    b. Certified valid BHF certificate
    c. Bank Statement not older than one month with a bank stamp.
    d. Proof of address not older than 3 months.
    e. Submit SARS Vat registration number document where applicable. If this is not provided the Medical Service Provider will be registered as a Non VAT vendor.
    f. Submit proof of dispensing licence where applicable.
2. A duly completed original Banking Details form (W.aC 33) that can be downloaded in PDF from the Department of Employment and Labour Website (www.labour.gov.za). Please note on completion this form must contain the relevant bank stamp.
3. 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.
4. The name of the switching house that submit invoices on behalf of the medical service provider.
5. These documents must be handed in to the nearest Labour centre for capturing.

Kindly take note of the following: All medical service providers will be subjected to the Compensation Fund vetting processes.

REGISTERING WITH THE COMPENSATION FUND AS AN ONLINE SYSTEM USER FOR MEDICAL SERVICE PROVIDER

To become an online user of the claims processing system Medical Service Providers must follow the following steps.

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

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2. Register on the CompEasy application
    a. The following documents must be at hand to upload
        i. A certified copy of identity document (not older than a month from the date of application)
        ii. Certified valid BHF certificate
        iii. Proof of address not older than 3 months
    b. 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
        i. An appointment letter for proxy (the template is available online)
        ii. The proxy's certified identity document (not older than a month from the date of application)
3. There is an online instructions to guide a user on registering as an online user (www.compeasy.gov.za)

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BILLING PROCEDURE TO BE ADHERED TO WHEN BILLING FOR MEDICAL SERVICES PROVIDED TO INJURED/DISEASED EMPLOYEES

1. All service providers should be registered on the Compensation Fund claims processing system in order to capture medical invoices and reports for medical services rendered.
2. Prior to submitting, uploading or switching medical invoices and supporting reports, medical service providers should ensure that the claim is one that the Compensation Fund has accepted liability for and therefore reasonable medical expenses can be paid.
3. Medical Reports:
    a. 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 also any referrals to other medical service providers where applicable.
    b. All follow up consultations must be completed on a Progress Medical Report (W.CL5). It must also detail any operation/procedure performed and also any referrals to other medical service providers where applicable.
        i. 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.
        ii. Only one medical report is required when multiple procedures are done on the same service date.
    c. When the injury/disease being treated stabilises a Final Medical Report must be completed (W.CL 5F).
    d. Medical Service Providers are required to keep copies of medical reports which should be made available to the Compensation Commissioner on request.
4. Medical Invoices
    a. The Compensation Fund allows the submission of invoices in 3 different formats, the use of a switching house, directly uploading the invoice onto the processing application and the receipt of manual invoices by Labour Centre's. The former two are encouraged for Medical Service Providers to use, whilst the last form is for Medical Service Providers who have a small amount of invoices to submit.
    b. Medical invoices should be switched to the Compensation Fund using the attached **format or electronic invoicing file layout**. It must be noted that the corresponding medical report must be uploaded online prior to the invoice data being switched, to avoid systematic rejections on receipt.
    c. The processing system has an online guide available to guide Medical Service Providers for the direct uploading of invoice on the application.
    d. The status of invoices /claims can be viewed on the Compensation Fund claims system. If invoices are still partially or wholly outstanding with no reason indicated, after 60 days following submission, the service provider should complete an enquiry form, W.CI 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)

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e. Manual invoices and their corresponding medical reports must be handed in to the nearest labour centre.

5. The progress status of successfully submitted invoices can be viewed on the Compensation Fund online portal/APP.
6. 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.
7. If a medical service provider claims an amount more than the published tariff amount for a code, the Compensation Fund will only pay the Gazetted amount.

NOTE: Templates of the following medical forms are available on the Department of Employment and Labour website (www.labour.gov.za)
First Medical Report (W.CL 4)
Progress/Final Medical Report (W.CL 5 / W.CL 5)

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MINIMUM OF INFORMATION TO BE INCLUDED ON 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, as indicated on the corresponding Employers Report of Accident (W.CL 2), for switched invoices
4. DATES:
   a. Date of accident
   b. Date of service (From and To)
5. Medical Service Provider BHF practice number
6. VAT registration number (VAT will not be paid if a VAT registration number is not supplied on the invoice)
7. Tariff Codes:
   a. Tariff code applicable to injury/disease as in the official published tariff guides
   b. Amount claimed per code and the total of the invoice
8. VAT:
   a. The tariff amounts published in the tariff guides to medical services rendered in terms of the COID Act of 1993 do not include VAT. All invoices for services rendered will be assessed without VAT. Only if it is indicated that the service provider is registered as a VAT vendor and a VAT registration number is provided, will VAT be calculated and added to the payment, without being rounded off.
   b. The only exception is the "per diem" tariffs for Private Hospitals that already include VAT.
   c. Please note that there are VAT exempted codes in the Private Ambulance tariff structure.
9. All pharmacy or medication invoices must be accompanied by the original scripts
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. Duplicate invoices should not be submitted.

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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REQUIREMENTS FOR SWITCHING MEDICAL INVOICES WITH THE COMPENSATION FUND

The switching provider / third party must comply with the following requirements:

1. Register with the Compensation Fund as an employer.
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. Validate 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 100 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. Medical Service Providers will be subjected to Compensation Fund vetting processes.
12. Third parties must submit a power of attorney.
13. Submit any information/documentation requested by the Fund.
14. Only pharmacies should claim from the NAPPI file.

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

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COMPEASY ELECTRONIC INVOICING FILE LAYOUT

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	

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29	Date of birth / ID number	13	Numeric	*
30	Service Switch transaction number – batch number	20	Alpha	
31	Hospital indicator	1	Alpha	*
32	Authorisation number	21	Alpha	*
33	Resubmission flag	5	Alpha	*
34	Diagnostic codes	64	Alpha	*
35	Treating Doctor BHF practice number	9	Alpha	
36	Dosage duration (for medicine)	4	Alpha	
37	Tooth numbers		Alpha	*
38	Gender (M, F)	1	Alpha	
39	HPCSA number	15	Alpha	
40	Diagnostic code type	1	Alpha	
41	Tariff code type	1	Alpha	
42	CPT code / CDT code	8	Numeric	
43	Free Text	250	Alpha	
44	Place of service	2	Numeric	*
45	Batch number	10	Numeric	
46	Switch Medical scheme identifier	5	Alpha	
47	Referring Doctor's HPCSA number	15	Alpha	*
48	Tracking number	15	Alpha	
49	Optometry: Reading additions	12	Alpha	
50	Optometry: Lens	34	Alpha	
51	Optometry: Density of tint	6	Alpha	
52	Discipline code	7	Numeric	
53	Employer name	40	Alpha	*
54	Employee number	15	Alpha	*
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	

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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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MSPs PAID BY THE COMPENSATION FUND

Discipline Code :	Discipline Description :
004	Chiropractors
009	Ambulance Services - Advanced
010	Anesthetists
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 Physician
019	Gastroenterology
020	Neurology
022	Psychiatry
023	Radiation/Medical Oncology
024	Neurosurgery
025	Nuclear Medicine
026	Ophthalmology
028	Orthopedics
030	Otorhinolaryngology
034	Physical Medicine
035	Emergency Medicine Independent Practice Specialist
036	Plastic and Reconstructive Surgery
038	Diagnostic Radiology
039	Radiography
040	Radiotherapy/Nuclear Medicine/Oncologist
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

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066	Occupational Therapy
070	Optometrists
072	Physiotherapists
075	Clinical technology (Renal Dialysis only)
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	Dieticians
086	Psychologists
087	Orthotists & Prosthetists
088	Registered nurses (Wound Care only)
089	Social workers
090	Clinical services : wheelchairs

OPTOMETRY TARIFF OF FEES AS FROM 01 APRIL 2023 (PRACTICE TYPE 70)		
Code	**Code Description**	**Rand**
11001	Optometric Examination **Note:** Relevant for replacement of spectacles or contact lenses	583.44
11046	Ocular Pathology Examination **Note:** When IOD has caused ocular injury	656.24
11061	Low Vision Examination **Note:** When IOD has caused deterioration of vision to sub-standard levels, or following IOD incident of low-vision patient	809.12
11246	Colour Vision Evaluation **Rule:** Can be billed in addition to 11001 or 11046 when necessary	206.75
11265	Contrast Sensitivity Evaluation **Rule:** Can be billed in addition to 11001 or 11046 when necessary	127.19
11356	Gonioscopy **Rule:** Can be billed in addition to 11001 or 11046 when necessary	281.01
11366	Dilated fundus examination with Fundus lens **Rule**: Can be billed in addition to 11001 or 11046 when necessary	278.72
11423	Visual field – Non threshold Testing **Rule:** Can be billed in addition to 11001 or 11046 when necessary	179.82
11443	Visual Field – Threshold Testing **Rule:** Can be billed in addition to 11001 or 11046 when necessary	314.70
11604	Photography of Anterior Segment **Rule:** Can be billed in addition to 11001 or 11046 when necessary	89.86
11624	Photography of Fundus **Rule:** Can be billed in addition to 11001 or 11046 when necessary	143.83
11702	Pachymetry **Rule:** Can be billed in addition to 11001 or 11046 when necessary	125.84
11802	Optical Coherence Tomography (OCT) Health screening **Rule:** Can be billed in addition to 11001 or 11046 when necessary	260.73
11803	Optical Coherence Tomography (OCT) Anterior **Rule:** Can be billed in addition to 11001 or 11046 when necessary	188.76
11804	Optical Coherence Tomography (OCT) Posterior **Rule:** Can be billed in addition to 11001 or 11046 when necessary	224.74
11906	Lacrimal Drainage System Patency **Rule:** Can be billed in addition to 11001 or 11046 in cases such as chemical or vapour exposure	332.59
15000	Removal of non embedded foreign body **Rule:** Can be billed in isolation or with 11001 or 11046 or 11061 or 15025 or 15030	215.80
15002	Removal of embedded; non-penetrating foreign body **Rule:** Can be billed in isolation or with 11001 or 11046 or 11061 or 15025 or 15030	315.12
15004	Removal of corneal foreign body **Rule:** Can be billed in isolation or with 11001 or 11046 or 11061 or 15025 or 15030	409.14
15025	Management of ocular pathology **Rule** : Cannot be billed with 15030 or 11001 or 11046 or 11061	791.13

15030	Management of ocular pathology – follow up **Rule** : Cannot be billed with 15025 or 11001 or 11046 or 11061	566.38
11141	Refractive Status evaluation **Note:** Appropriate after IOD incident to monitor recovery of the eye.	224.74
11183	Keratometry **Note:** Appropriate for fitting of contact lens or monitoring of corneal recovery after IOD to the eye	112.42
11202	Tonometry without anaesthetic **Note:** After ocular IOD cases only	134.89
11212	Tonometry with anaesthetic **Note:** After ocular IOD cases only	179.82
11402	Visual field – screening **Note:** Relevant in cases of head and/or ocular injury	143.83
11838	Glaucoma investigation code Relevant in cases of ocular injury	233.79
	Lens	
Code	**Code Description**	**Rand**
11501	Dispensing fee – single vision basic **Rule :** Only with replacement of spectacle lenses code 81BS001	80.91
11521	Dispensing fee – Bifocals **Rule :** Only with replacement of spectacle lenses code 84BS001	107.85
11541	Dispensing fee – Varifocal distance to near **Rule :** Only with replacement of spectacle lenses code 86BS001	134.89
11503	Dispensing fee – Single Vision Surfaced **Rule :** Only with replacement of spectacle lenses code 82BS001	107.85
11531	Dispensing Fee – Accommodative Support **Rule :** Only with replacement of spectacle lenses code 83BS001	107.85
11540	Dispensing fee – Intermediate to near **Rule :** Only with replacement of spectacle lenses code 85BS001	107.85
Note	**For Single vision, Bifocal, Varifocal the below applies** LENS CODES: Replacement lenses after ocular injury if lenses were broken or if treatment changed due to IOD incident. **Rule:** A claim is limited to a maximum of 2 replacements. Occasionally there may be a combination of 2 different codes, but never a code starting with 8 together with a code starting with 7	
81BS001	Single Vision (standard) CR39	225.26
82BS001	Single Vision (surfaced) CR39	507.42
83BS001	Accommodative support lens	507.42
84BS001	Bifocals CR39	566.59
85BS001	Varifocal Intermediate to near	983.53
86BS001	Varifocal Distance to near	983.53
71BS001	Single Vision (standard) Glass	225.26
72BS001	Single Vision (surfaced) Glass	507.42
74BS001	Bifocal Glass	566.59
76BS001	Varifocal Distance to Near Glass	983.53

40501	Spectacle frame **Note:** Frame and lens will only be issued if the eye condition is IOD incident.	926.65
Note	**For Unbranded HRI the below applies:** LENS ENHANCEMENTS CODES: Where lenses are replaced as result of IOD, and treatment is greater than +4.00D (sphere) or -6.00D (sphere + cyl, or cyl is greater than -2.00) **Note:** First 2 digits must align with first 2 digits of lens codes	
81UB003	Unbranded HRI single vision stock	2560.79
83UB002	Unbranded HRI Accommodative Support	1895.19
86UB006	Unbranded HRI Varifocal Distance/Near	2243.59
Note	Contact lenses can be either elective or clinically essential. Elective lenses are selected as a convenience or cosmetic preference by the wearer. Clinically essential contact lenses are necessary where adequate vision can only be achieved by the application of a contact lens. Contact lenses are manufactured in a number of different materials and modalities. On a high level there are rigid and soft lenses. Both fall into 2 major sub-categories: Rigid: corneal and scleral. Rigid lenses Can last for a number of years, if well cared. Soft lenses: Disposable and Non-disposable. Non-disposable mostly have a lifespan of 12 months. Disposable may be replaceable daily, weekly, or monthly. Note: Where contact lenses were damaged in the IOD, they will only require replacement once. The employee would have been responsible for routine replacement prior to the IOD incident, and is therefore responsible thereafter. Note: Where the IOD incident had made contact lenses clinically essential they will require ongoing replacement as per the replacement schedule. Note: MOTIVATIONIS REQUIRED FOR CONTACT LENSES AND WILL BE PAYABLE BASED ON THE REASONABILITY DETERMINED BY THE FUND.	
24022	Rigid contact lens where rigid contact lens is damaged in IOD,or injury to eye requires rigid lens	3600.00
24024	Rigid scleral contact lens	7500.00
Note	Where IOD incident resulted in Low Vision status (normal visual function cannot be achieved with spectacles or contact lenses) one or more low vision devices are appropriate.	
61013	LVA – Single Element	2500.00
61114	LVA – Multiple Elements Fixed Focus	2600.00
61215	LVA – Multiple Element Variable focus	15000.00
61318	LVA – Electronic	12000.00

61320	Software aided vision program	1300.00
Ocular Prosthetics		
Note	Claims for Ocular Prostheses are for the fitting of a prosthesis after removal of the eye due to injury or pathology, and replacement of the prosthesis at the end of its life, and for the maintenance of the prosthesis in the interim. Correctly manufactured and maintained prostheses should last approximately 5 years. They should be annually 'serviced' to maintain the surface of the prosthesis and thereby prevent deterioration and / or physiological issues from reducing the lifespan of the prostheses and / or resulting in the need for additional medical or surgical intervention.	
56000	Complete Eye **Note:** Where IOD has resulted in the enucleation (removal) of the eye. The code covers all aspects of the fitting of a complete prosthesis, including 6 months of after care. **Note:** Repeats are allowed without intervention after 48 months.	23780.22
56001	Polishing	407.39
56010	Complete Haptic Shell **Note**: Where IOD has damaged and blinded the eye, but not necessitated enucleation. The code covers all aspects of the fitting of a complete prosthesis, including 6 months of after care **Note**: Repeats are allowed without intervention after 48 months	
59001	Annual Maintenance **Note:** Not billable within 6 months of the fitting of code 56000 or 56010 prosthesis. Code can be billed together with 53015.	2541.45
53015	Prosthetic Consultation code Can be Billed together with 59001, or where annual visit codes 56000 or 56010 Can be billed but does not necessitate maintenance 59001	797.99
70081	Optometric examination and visual field screening consultation	579.05
70021	Optometric re-examination within six months of 70081 follow up	330.94
70503	Walking Stick/Cane for the blind	360.88