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DEPARTMENT OF EMPLOYMENT AND LABOUR

NO. 4579 **28 March 2024**

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employment & labour
Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA
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 EMPLOYMENT & 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 2024**.
2. Medical Tariffs increase for **2024/25 are** as follows:
   2.1. HOSPITAL TARIFFS: To be increased between 0% - 9.7% as applicable
   2.2. Non HOSPITAL TARIFFS: 5.4%
3. The fees appearing in the Schedule are applicable in respect of services rendered from 1 **April 2024 for the financial year 2024/25** and **exclude 15% VAT**.

MR TW NXESI, MP
MINISTER OF EMPLOYMENT AND LABOUR
DATE: 23/01/2024

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COID MEDICAL TARIFFS GENERAL INFORMATION

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

2. 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):

1. 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.
    a. The only exception 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 COID Act refers.
2. In terms of Section 42 of The COID 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.
3. 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. 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.
5. 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. As a general rule, changes of Medical Service Providers are not encouraged by The Compensation Fund, unless sufficient reasons exist for such a change.

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6. 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.
7. 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.
8. The Compensation Fund could 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.
9. Proof of identity is required in order for a claim to be registered with The Compensation Fund.
    a. In the case of a South African citizen, a copy of a South African Identity Document.
    b. In the case of foreign nationals, the proof of identity (Passport) must be certified.
10. All supporting documentation submitted to The Compensation Fund must reflect the identity and claim numbers of the employee.
11. The completion of medical reports cannot be claimed separately, fees quoted in the COID medical tariffs are inclusive of medical report completion.
12. The tariff amounts published in the COID medical tariffs guides, for services rendered do not include VAT unless otherwise specified. All invoices for services will therefore be assessed without VAT.
    a. VAT will be applied without rounding off, to invoices for service providers that have confirmed their VAT vendor status through the submission of their VAT registration number.
13. All Medical Service Providers transacting with The Compensation Fund will be subject to a vetting process
14. All Medical Service Providers must ensure that they are compliant with the Board of Health Funders to avoid payments being due to them being withheld.
15. Medical Service Providers may be requested to grant The Compensation Fund access to their premises for auditing purposes.

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3. OVERVIEW OF COID CLAIMS PROCESS

All claims lodged in the prescribed manner with The Compensation Fund undergo the following process:

1. New claims are registered by the Employers with The Compensation Fund. Details and progress of the claim can be viewed on the online processing system for registered online users.
2. The allocation of a claim number after the registration of the claim by The Compensation Fund, does not constitute acceptance of liability. It confirms the injury on duty has been reported and receipt acknowledged by The Compensation Fund.
3. 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.
    a. Please note that there are claims on which a decision might never be taken due to the non-submission of outstanding information.
4. If a claim is repudiated in terms of the COID Act medical expenses for services rendered, 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. Reasonable medical expense in terms of the COID Act, become payable subsequent to the acceptance of liability by The Compensation Fund.
    a. Reasonable medical expense shall be paid in line with approved tariffs, billing rules and procedures published in COID medical tariffs.
    b. Only medical treatment related to the injury/disease shall be payable.
6. Reasonable medical expenses for COID claims where liability has been accepted (adjudicated) on or after 01 April 2024:
    a. 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.
    b. Payment may be rejected/withheld for medical invoices that fail to meet the requirements as set is 6(a).

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4. COID REGISTRATION REQUIREMENTS FOR MEDICAL SERVICE PROVIDERS

The Compensation Fund requires that any Medical Service Provider who intends to treat patients in terms of the COID Act, must register this intent by following the registration process as below:

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. Their most recent bank statement with the 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.
    g. A power of attorney is required where the Medical Service Provider has appointed a third party for administration of their COID claims.
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).
3. Submit the following additional information on the Medical Service Providers letterhead, Cell phone number, Business contact number, Postal address and Email address. The Compensation Fund must be notified in writing of any changes to contact details.

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5. REGISTRATION PROCESS:TO BECOME COID ONLINE SYSTEM USER FOR MEDICAL SERVICE PROVIDERS

To become an online user of the claims processing system, Medical Service Providers please do as follow steps.

1. Register as an online user with the Department of Employment and Labour on its website (www.labour.gov.za)
2. Register on the CompEasy application:
    a. The following documents must be at hand to be uploaded
        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 makes use of a third party to access the claims processing system on their behalf, 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 are instructions online to guide a user on successfully registering (www.compeasy.gov.za)

6. REQUIREMNTS FOR THIRD PARTIES TRANSACTING WITH THE COMPENSATION FUND ON BEHALF OF MEDICAL SERVICE PROVIDERS

Third Parties that administer invoices on behalf of Medical Service Providers must comply with the following:

1. A third-party transacting with The Compensation Fund, must be capable of obtaining original claim documents and medical invoices from Medical Service Providers.
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
3. The Compensation Fund shall not provide or disclose any information related to a Medical Service Provider who is contracted to a third party where such information was obtained or relates to a period prior to an agreement between Medical Service Provider and a third party.

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7. COID REQUIREMENTS 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 medical reports.
2. Medical reports and medical invoices should **ONLY** be submitted/transmitted for claims that The Compensation Fund has accepted liability for and reasonable medical expenses are payable.
3. 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:
   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 any referrals to other medical service providers where applicable.
   b. 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.
      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 demand.
4. Medical Invoices:
   a. The ICD-10 validations will apply as per the national ICD-10 phase 3 and phase 4.1 requirements. Note that these phases were implemented on 01 July 2014 and entail the following:
      i. Valid and ICD-10 codes as the SA ICD-10 Master Industry Table
      ii. Maximum level of specificity: ICD-10 codes to be valid at the correct 3rd,4th 0r 5th
      iii. character level.
      iv. Valid ICD-10 primary codes, codes not valid as primary will be rejected
      v. Comply with the dagger and asterisk rule
      vi. Comply with the sequelae coding rules
      vii. Age edits for ICD-10 codes that have age requirements
      viii. Gender edits

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ix. All injury and poisoning codes must be accompanied by external cause codes

b. The Compensation Fund allows the submission of invoices in 3 different formats:
   i. Switching of invoices: Medical invoices should be switched to The Compensation Fund using the approved format/ 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 system rejections on receipt.
   ii. Direct uploading of invoices onto the processing application (External APP): The processing system has an online guide available to guide Medical Service Providers for the direct uploading of invoice on the application.
   iii. Receipt of manual invoices by Labour Centres.

   The first two options are encouraged for ease of processing.

c. The progress of claims/invoices may be viewed on The Compensation Funds processing system.
d. If invoices are partially or wholly outstanding with no reason indicated after 60 days of submission, a medical service provider should enquire by completing an Enquiry Form W.CI-20 and submit it **ONCE** to nearest Labour Centre. Details regarding Labour Centres are available on the website (www.labour.gov.za)

5. When a Medical Service Provider claims an amount less than the published tariff amount for a code, The Compensation Fund will pay the claimed amount.
6. When a Medical Service Provider claims an amount more than the published tariff amount for a code, The Compensation Fund will pay the Gazetted amount.
7. Medical Service Provider are required to keep copies of medical invoices, medical report and any other claim documents and make these available to The Compensation Commissioner on request.
8. Medical Service Provider should not generate multiple invoices for services rendered on the same date i.e. one invoice for medication and the second invoice for other services.

NOTE: 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)**

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8. MINIMUM INFORMATION REQUIRED 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 Identity number of the 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 (Medical Service Providers) 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 copies of the original script(s)
10. Where applicable the referral letter from the treating practitioner must accompany the Medical Service Provider's invoice.
11. All medical invoices must be submitted with invoice numbers to prevent system rejections.
12. Duplicate invoices should not be submitted.
13. The Compensation Fund does not accept submission of running accounts /statements.

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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9. REQUIREMENTS FOR SWITCHING MEDICAL INVOICES TO 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 Compensation 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 administrator, and require staff to use multifactor authentication
3. Submit a complete successful test file after registration before switching 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.

NOTE: 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

*** 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	*

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FIELD	DESCRIPTION	MAX LENGTH	DATA TYPE	MANDATORY
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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FIELD	DESCRIPTION	MAX LENGTH	DATA TYPE	MANDATORY
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	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)

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060	Pharmacy
062	Maxillo-facial and Oral Surgery
064	Orthodontics
066	Occupational Therapy
070	Optometry
072	Physiotherapy
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	Dietician
086	Psychology
087	Orthotists & Prosthetics
088	Registered Nurses (Wound Care only)
089	Social Worker
090	Clinical Services: (Wheelchairs and Gases only)
094	Prosthodontic

RADIOGRAPHY GAZETTE 2024

RADIOGRAPHY TARIFF OF FEES AS FROM 1 APRIL 2024 (PRACTICE TYPE 039)		
DIAGNOSTIC PROCEDURES		
General Rules		
Rule	**Rule Description**	
001	**Note:**Items 015,029,031,033,037,065,071,075,077,079,081,087,089,115, 117,119,121,129,135, 137,139 and167 should be only be paid on condition that the radiographer submits the name of the supervising clinician and his/her BHF practice number.	
002	Radiographer invoices will only be paid on condition that there is a referral letter from a treating practitioner.	
Modifiers		
Modifier	**Modifier Description and Standards**	**Rand**
Addition Modifier (AM)	This modifier will add a value by using a percentage value or a unit value to a procedure code. The modifier should be quoted on a separate line with its own value instead of adding its value to the code.	
Compound Modifiers (CM)	The modifier should be quoted on a separate line with its own value at the end of the invoice instead of adding its value to the code. It should be indicated on each procedure code where the modifier is applicable.	
Reduction Modifiers (RM)	This modifier reduces the value of a procedure code/s by using a percentage or unit value.It should be quoted on the procedure codes where the modifier is applicable.	
Information Modifier (IM)	This modifier provides additional information to a procedure code and carries no financial value. It should be indicated on each procedure codes where the modifier is applicable.	
M0001	AM: Emergency fee	**75.80**
M0021	IM: Services rendered to hospital patients: Quote modifier 0021 on all accounts for services performed on hospital or day clinic patients.	
M0080	IM: Multiple examinations: Full fees	
M0081	IM: Repeat examinations: No reduction	
M0084	IM: Film Cost : The cost of film is included in the comprehensive procedure codes and is not billed separately	
Tariff Codes		
Code	**Code Description**	**Rand**
1.	**Skeleton**	
1.1	**Limbs**	
39001	Finger, toe	**268.45**
39201	Limb per region, e.g. Shoulder, (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**377.86**
39202	Limb per region, e.g. Elbow (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**340.86**
39203	Limb per region, e.g. Knee (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**360.57**
39204	Limb per region, e.g. Foot, (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**303.97**
39205	Limb per region, e.g. Hand (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**334.43**
39206	Limb per region, e.g. Wrist (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand	**345.08**
39207	Limb per region: Ankle (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**360.57**
39208	Limb per region: Scaphoid (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**358.47**
39209	Limb per region: Radius and ulna (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**319.36**
39210	Limb per region: Humerus (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	**319.36**

39211	Limb per region: Acromio-Clavicula joint (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	340.86
39212	Limb per region: Clavicle (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	330.43
39213	Limb per region: Scapula (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	330.43
39214	Limb per region: Calcaneus (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	297.54
39215	Limb per region: Tibia and Fibula (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	319.36
39216	Limb per region: Patella (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	300.81
39217	Limb per region: Femur (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	319.36
39218	Limb per region: Hip (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	345.08
39219	Limb per region: Sesamoid Bone (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand).	303.97
39005	Smith-Petersen or equivalent control, in theatre Use once per sitting	894.91
39007	Stress studies, e.g. joint	339.37
39009	Length studies per right and left pair of long bones Only use once for both pair of bones.	463.13
39220	Limb per region: Acromio-Clavicula joint (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	262.75
1.2	**Spinal Column**	
39017	Per region, e.g. cervical, sacral, coccygeal, one region thoracic Code can be used multiple times for different anatomical sites of the spine.	185.93
39301	Cervical Spine - 2 or more views	501.81
39302	Per region, e.g. Sacral	471.51
39303	Per region, e.g. Coccygeal	471.51
39304	Thoracic Spine 2 Views	376.28
39305	Lumbar Spine - 2 or more views	522.68
39021	Stress studies	66.87
39027	Pelvis (sacro-iliac or hip joints only to be added where an extra set of views is required).	384.09
	Myelography	
39029	Lumbar	286.76
39031	Thoracic	266.70
39033	Cervical	395.17
39035	Multiple (lumbar, thoracic, cervical): Same fee as for first segment (no additional introduction of contrast medium) Refer to general rule 001.	-
39037	Discography (Refer to general rule 001)	209.37
1.3	**Skull**	
39039	Skull studies	404.81
39041	Paranasal sinuses	384.09
39043	Facial bones and/or orbits	412.27
39045	Mandible	384.09
39047	Nasal bone	250.80
39049	Mastoid: Bilateral	753.06

1.3.1	**Teeth**	
39051	One quadrant	**209.81**
39053	Two quadrants	**265.49**
39055	Full mouth	**248.50**
39057	Rotation tomography of the teeth and jaws	**425.97**
39059	Temporo-mandibular joints: Per side	**373.35**
39061	Tomography: Per side	**202.68**
39063	Localisation of foreign body in the eye	**373.35**
39065	Ventriculography (Refer to general rule 001)	**248.83**
39067	Post-nasal studies: Lateral neck	**167.71**
39069	Maxillo-facial cephalometry	**173.60**
39071	Dacryocystography (Refer to general rule 001)	**156.20**
2.	**Alimentary Tract**	
39075	Pharynx and oesophagus (Refer to general rule 001)	**151.60**
39077	Oesophagus, stomach and duodenum (control film of abdomen included) and limited follow through (Refer to general rule 001).	**209.37**
39079	Small bowel meal (control film of abdomen included, except when part of tariff code 39081) (Refer to general rule 001).	**184.26**
39081	Barium meal and dedicated gastro-intestinal tract follow through (including control film of the abdomen, oesophagus, duodenum, small bowel and colon) (Refer to general rule 001).	**314.05**
39087	Gastric/oesophageal/duodenal intubation control (Refer to general rule 001)	**138.23**
3.	**Chest**	
39105	Larynx (tomography included)	**282.04**
39107	Chest (tariff code 39167 included)	**405.47**
39109	Chest and cardiac studies (tariff code 39167 included)	**153.57**
39111	Ribs	**452.28**
39113	Sternum or sterno-clavicular joints	**530.21**
3.1	**Bronchography**	
39115	Unilateral (Refer to general rule 001)	**215.18**
39117	Bilateral .Cannot be used with tariff code 39115 (Refer to general rule 001)	**375.98**
39119	Pleurography (Refer to general rule 001)	**104.46**
39121	Laryngography (Refer to general rule 001)	**104.46**
39123	Thoracic inlet	**268.34**
4.	**Abdomen**	
39125	Control films of the abdomen (not being part of examination for barium meal, pyelogram, etc.).	**348.25**
39127	Acute abdomen or equivalent studies	**562.22**
5.	**Urinary Tract**	
39129	Control film included and bladder views before and after micturition (Refer to general rule 001)	**445.70**
39135	Cystography only or urethrography only (retrograde) (Refer to general rule 001)	**250.03**
5.1	**Cysto-Urethrography**	
39137	Retrograde (Refer to general rule 001)	**220.11**
39139	Retrograde-prograde pyelography (Refer to general rule 001)	**282.04**
39143	Tomography of renal tract: Add to item for examination performed	**127.48**

6.	**Tomography and Cinematography**	
39151	Tomography (conventional except where otherwise specified): Add 100% provided that if it is more than one dimension, fees shall be charged for the additional investigation at 50% of the rate with a maximum of two additional investigations.	-
39153	Tomography (multi-dimensional in motion): Add 150%	-
7.	**Computed Tomography**	
Modifier governing this specific section of the Tariffs		
Modifier	**Modifier Description**	
M0089	RM: The number of sections of each examination and the matrix number must be specified. A full series of sections would be 8 or more for brain examinations, 12 or more for chest examinations, and 16 or more for abdomen examinations. Fees for examinations on a matrix number of less than 250 shall be reduced by 50%.	
39155	Head, single examination, full series	**1 747.06**
39157	Head, repeat examination at the same visit, after contrast, full series	**599.60**
39159	Chest	**2 019.78**
39161	Abdomen (including base of chest and/or pelvis)	**2 347.54**
39163	Multiple examinations: For an additional part, the lesser fee shall be reduced to 50%	**546.00**
39165	Limbs and other limited examinations	**546.00**
8.	**Miscellaneous**	
39167	Fluoroscopy: Per half hour: Add to item for examination performed (not applicable to tariff code 39107 and 39109) (Refer to Rule 001) Reflect time on the invoice.	**142.50**
39169	Where a C-arm portable x-ray unit is used in hospital or theatre: Per half hour: Add to item for examination performed Reflect time on the claim or invoice.	**196.76**
39179	Attendance at operation in theatre or at radiological procedure performed by a surgeon or physician in x-ray department except 005: Per 1/2 hour: Plus fee for examination performed Reflect time on the claim or invoice.	**117.07**
39181	Setting of sterile trays Use tariff code 39181 once per sitting regardless of the number of procedures done.	**19.95**
39300	X-Ray films (Refer to modifier 0084)	-
	Attendance In Catheterisation Laboratory	
	Use codes 191 to 192 to charge for radiographer input where that is not included in cath lab facility fee.	
39191	Preparation in catheterisation laboratory for purposes of invasive intravascular procedures.	**285.99**
39192	Post-processing in catheterisation laboratory for purposes of invasive intravascular procedures.	**285.99**
39199	Vascular Study per 30 minutes or part thereof provided that such part comprises 50% or more of the time Reflect time on the claim or invoice.	**285.99**

Rules		
Z	No fee to be subject to more than one reduction	
9.	**Portable Unit Examinations**	
39185	Where portable x-ray unit is used in the hospital or theatre: Add to tariff code for examination performed.	**129.02**
39187	Theatre investigations with fixed installation : Add to tariff code for examination performed.	**55.14**

DIETICIAN GAZETTE 2024

DIETICIAN TARIFF OF FEES AS FROM 01 APRIL 2024 (PRACTICE TYPE 084)		
General Rules		
Rule	**Rule Description**	
001	Referral by the principal doctor with a copy of the referral letter is required.Only one visit per day and a maximum of 7 (seven) visits per claim are allowed. Motivation letter is required if more than seven visits are required.	
003	Dietary services are per individual patient.	
011	Compilation of reports: To be used to motivate for therapy and give a progress report, where such a report is specifically required by the Compensation Fund.	
Modifiers		
Modifier	**Modifier Description**	
0021	IM: Services to hospital inpatients: Quote modifier 0021 on all invoices for services performed on hospital inpatients.	
Tariff Codes		
Code	**Code Description**	**Rand**
1.	**Individual Assessment,Counselling and/or Treatment**	
84206	Initial hospital visit: Nutritional assessment, counselling and/or treatment. Duration: 61-70min. Report is required and item includes compilation of report. The relevant modifier applies.	827.16
84201	Follow up hospital visit in the ward: Nutritional assessment, counselling and/or treatment. Duration: 11-20min. Report is required and item includes compilation of report. The relevant modifier applies.	177.14
84203	Hospital follow up visit in ICU and High Care Unit: Nutritional assessment, counselling and/or treatment. Duration: 31-40min. Report is required and item includes compilation of report. The relevant modifier applies.	531.86
84205	Final hospital visit: Nutritional assessment, counselling and/or treatment. Duration: 51-60min. For discharge menu planning and counselling. Final report is required and item includes compilation of report. The relevant modifier applies.	649.69

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Contact Centre Tel: 012-748 6200. eMail: info.egazette@gpw.gov.za
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