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Contents

DEPARTMENT OF EMPLOYMENT AND LABOUR

NO. 3149 **22 April 2025**

AMENDMENT GAZETTE

DOCTORS, PHYSIOTHERAPY, OCCUPATIONAL THERAPY AND SOCIAL WORKER SERVICES 2025-2026

DEPARTMENT OF EMPLOYMENT AND LABOUR

AMENDMENT FOR DOCTORS GAZETTE, NOTICE 3083 PUBLISHED ON 25 MARCH 2025, NO: 52377

DOCTORS CLINICAL PROCEDURES

			Specialist		General Practitioner		Anaesthetic		
Code	Code Description		U	R	U	R	U	R	T
0389	Fracture (reduction under general anaesthetic): Humerus		129.6	4,271.62	129.6	4,271.62	3	462.09	+T+M
0391	Fracture (reduction under general anaesthetic): Radius and/or Ulna		135.7	4,472.67	120	3,955.20	3	462.09	+T+M
0392	Open reduction of both radius and ulna (Modifier 0051 not applicable)		193.5	6,377.76	154.8	5,102.21	3	462.09	+T+M
0403	Bennett's fracture-dislocation		84.5	2,785.12	84.5	2,785.12	3	462.09	+T+M
0405	Fracture reduction under general anaesthetic: Open treatment of Metacarpal: Simple		75.4	2,485.18	75.4	2,485.18	3	462.09	+T+M
0413	Fracture (reduction under general anaesthetic): Finger phalanx: Proximal or middle Replaces tariff code 0415		50.5	1,664.48	50.5	1,664.48	3	462.09	+T
0419	Fracture (reduction under general anaesthetic): Pelvis: Open reduction and internal fixation (Modifier 0051 not applicable)		354.49	11,683.99	283.59	9,347.13	3	462.09	+T+M
0421	Fracture (reduction under general anaesthetic): Femur: Neck or Shaft		279.1	9,199.14	223.3	7,359.97	3	462.09	+T+M
0425	Fracture (reduction under general anaesthetic) Patella		82.5	2,719.20	82.5	2,719.20	3	462.09	+T+M
0435	Fracture (reduction under general anaesthetic: Malleolus of ankle		126.8	4,179.33	120	3,955.20	3	462.09	+T+M
0438	Open reduction Talus fracture (Modifiers 0051,0052 not applicable)		311.6	10,270.34	249.3	8,216.93	3	462.09	+T+M
0439	Fracture (reduction under general anaesthetic): Tarsal bones (excluding talus and calcaneus)		76.6	2,524.74	76.6	2,524.74	3	462.09	+T+M
0441	Fracture (reduction under general anaesthetic): Metatarsal		66.8	2,201.73	66.8	2,201.73	3	462.09	+T+M
0475	Bonegrafting or internal fixation for malunion or non-union: Femur, Tibia, Humerus, Radius and Ulna		328.2	10,817.47	262.6	8,655.30	3	462.09	+T+M
0547	Dislocation: Clavicle either end		96.5	3,180.64	96.5	3,180.64	3	462.09	+T+M
0549	Dislocation: Shoulder		112.1	3,694.82	112.1	3,694.82	3	462.09	+T+M
0551	Dislocation: Elbow		133.6	4,403.46	120	3,955.20	3	462.09	+T+M
0552	Dislocation: Wrist		115.5	3,806.88	115.5	3,806.88	3	462.09	+T+M
0556	Dislocation: Carpo-metacarpo joint		117.2	3,862.91	117.2	3,862.91	3	462.09	+T+M
0557	Dislocation: Metacarpo-phalangeal or interphalangeal joints (hand)		107.3	3,536.61	107.3	3,536.61	3	462.09	+T+M
0559	Dislocation: Hip		220.5	7,267.68	176.4	5,814.14	3	462.09	+T+M
0561	Dislocation: Knee, with manipulation		181.2	5,972.35	145	4,779.20	3	462.09	+T+M
0563	Dislocation: Patella		136.9	4,512.22	120	3,955.20	3	462.09	+T+M
0565	Dislocation: Ankle		98.6	3,249.86	98.6	3,249.86	3	462.09	+T+M
0567	Dislocation: Sub-Talar dislocation		92	3,032.32	92	3,032.32	3	462.09	+T+M

0571	Dislocation: Meta-tarsophalangeal or interphalangeal joints (foot)		*39.4*	**1,298.62**	*39.4*	**1,298.62**	*3*	**462.09**	+T+M
0673	Menisectomy or operation for other internal derangement of knee: Medial OR lateral		*185.7*	**6,120.67**	*148.6*	**4,897.86**	*3*	**462.09**	+T+M
0677	Joint ligament reconstruction or suture: Knee: Collateral		*196.8*	**6,486.53**	*157.44*	**5,189.22**	*3*	**462.09**	+T+M
0678	Joint ligament reconstruction or suture: Knee: Cruciate		*227.6*	**7,501.70**	*182.1*	**6,002.02**	*3*	**462.09**	+T+M
0679	Joint ligament reconstruction or suture: Ligament augmentation procedure of knee		*324.4*	**10,692.22**	*259.5*	**8,553.12**	*3*	**462.09**	+T+M
0680	Joint ligament reconstruction or suture: Digital joint ligament		*229.8*	**7,574.21**	*183.84*	**6,059.37**	*3*	**462.09**	+T+M
0682	Amputation: Fore-quarter amputation		*397.8*	**13,111.49**	*318.24*	**10,489.19**	*9*	**1386.27**	+T+M
0683	Amputation: Through shoulder		*323*	**10,646.08**	*258.4*	**8,516.86**	*5*	**770.15**	+T+M
0687	Amputation: Metacarpal: One ray		*206.1*	**6,793.06**	*164.9*	**5,435.10**	*3*	**462.09**	+T+M
0691	Amputation: Finger or thumb		*183.9*	**6,061.34**	*146.4*	**4,825.34**	*3*	**462.09**	+T+M
0693	Hindquarter amputation		*470.7*	**15,514.27**	*376.6*	**12,412.74**	*6*	**924.18**	+T+M
0695	Amputation: Through hip joint region		*373.1*	**12,297.38**	*298.5*	**9,838.56**	*6*	**924.18**	+T+M
0697	Amputation: Through thigh		*245*	**8,075.20**	*196*	**6,460.16**	*6*	**924.18**	+T+M
0699	Amputation: Below knee, through knee/Syme		*277.2*	**9,136.51**	*221.8*	**7,310.53**	*5*	**770.15**	+T+M
0706	Post-amputation reconstruction: Skin flap taken from a site remote from the injured finger or in cases of an advanced flap e.g. Cutler		*186.3*	**6,140.45**	*149.04*	**4,912.36**	*3*	**462.09**	+T+M
0707	Post-amputation reconstruction: Krukenberg reconstruction		*331.7*	**10,932.83**	*265.4*	**8,747.58**	*3*	**462.09**	+T+M
0711	Post-amputation reconstruction: Pollicization of the finger (Prior permission must be obtained from the Commissioner at all times)		*455.9*	**15,026.46**	*364.72*	**12,021.17**	*3*	**462.09**	+T+M
0773	Extensor tendon suture: Secondary (per tendon, Modifier 0005 not applicable)		*170*	**5,603.20**	*136*	**4,482.56**	*3*	**462.09**	+T
0774	Repair of Boutonniére deformity or Mallet Finger with graft		*216.6*	**7,139.14**	*216.6*	**7,139.14**	*3*	**462.09**	+T
0776	Reconstruction of pulley for flexor tendon (modifier 0005 applicable)		*180.2*	**5,939.39**	*144.16*	**4,751.51**	*3*	**462.09**	+T
0782	Carpal tunnel syndrome		*123*	**4,054.08**	*120*	**3,955.20**	*3*	**462.09**	+T
0785	Flexor tendon freeing operation following free tendon graft or suture		*276.1*	**9,100.26**	*220.88*	**7,280.20**	*3*	**462.09**	+T
0787	Extensor tendon freeing operation following graft or suture in finger, hand or forearm		*212.2*	**6,994.11**	*170*	**5,603.20**	*3*	**462.09**	+T
0790	Tenodesis: Digital joint		*176.2*	**5,807.55**	*140.96*	**4,646.04**	*3*	**462.09**	+T
0803	Hand tendons: Single transfer (each) (modifier 0005 applicable)		*216.2*	**7,125.95**	*172.96*	**5,700.76**	*3*	**462.09**	+T
0809	Hand tendons: Substitution for intrinsic paralysis of hand/hand tendon (all four fingers)		*330.6*	**10,896.58**	*264.48*	**8,717.26**	*3*	**462.09**	+T
0812	Percutaneous Tenotomy: All sites		*140.5*	**4,630.88**	*120*	**3,955.20**	*3*	**462.09**	+T
0883	Removal: Implant, e.g. buried wire/pin/rod, superficial (Readily accessible).		*44.4*	**1,463.42**	*44.4*	**1,463.42**	*3*	**462.09**	+T
0884	Removal: Implant, e.g. buried wire/pin/screw/metal band/nail/rod/plate, deep (Less accessible).		*127*	**4,185.92**	*120*	**3,955.20**	*5*	**770.15**	+T
0888	Application of short limb cast (forearm, lower leg) (excluding aftercare) (first cast included in procedure) Modifier 0005 does not apply.		*18.4*	**606.46**	*18.4*	**606.46**	*3*	**462.09**	+T

0889	Application of spica, plaster jacket or hinged cast brace (excluding aftercare) (first cast included in procedure) Modifier 0005 does not apply.		*41.4*	**1,364.54**	*41.4*	**1,364.54**	*4*	**616.12**	+T
1022	Functional reconstruction of nasal septum Procedures of the septum including correction of caudal septal deflection is included. Tariff code 1087 may apply if a tip deformity and valve obstruction is present.		*121.2*	**3,994.75**	*120*	**3,955.20**	*4*	**616.12**	+T
1035	Unilateral functional endoscopic sinus surgery (unilateral)		*140*	**4,614.40**	*120*	**3,955.20**	*4*	**616.12**	+T
1036	Endoscopic ethmoid surgery: Bilateral, total ethmoid sinuses. May not be used with tariff code 1035 Modifier 0005 applies		*245*	**8,075.20**	*196*	**6,460.16**	*4*	**616.12**	+T
1055	External frontal ethmoidectomy		*190.7*	**6,285.47**	*152.56*	**5,028.38**	*4*	**616.12**	+T
1057	External ethmoidectomy and/or sphenoidectomy (unilateral)		*199.4*	**6,572.22**	*159.52*	**5,257.78**	*4*	**616.12**	+T
1059	Craniectomy: For osteomyelitis (total procedure)		*341.6*	**11,259.14**	*273.28*	**9,007.31**	*4*	**616.12**	+T
1085	Total reconstruction of the nose: Including reconstruction of nasal septum (septumplasty) nasal pyramid (osteotomy) and nasal tip		*350*	**11,536.00**	*280*	**9,228.80**	*5*	**770.15**	+T
1087	Subtotal reconstruction consisting of any two of the following: Septumplasty, osteotomy, nasal tip reconstruction		*210*	**6,921.60**	*168*	**5,537.28**	*5*	**770.15**	+T
4904	Laryngectomy: Total, with radical neck dissection May not be used with tariff code 1471		*508.7*	**16,766.75**	*406.96*	**13,413.40**	*7*	**1078.21**	+T
1136	Nebulisation (in rooms)		*12*	**395.52**	*12*	**395.52**		Fees as for specialist	
1137	Bronchial lavage						*8*	**1232.24**	+T
1142	Intra-pleural block		*36*	**1,186.56**	*36*	**1,186.56**	*3*	**462.09**	+T
1163	Excision tracheal stenosis: Cervical		*375*	**12,360.00**	*300*	**9,888.00**	*8*	**1232.24**	+T
1445	Radical excision of lymph nodes of neck: Total: Unilateral		*315*	**10,382.40**	*252*	**8,305.92**	*5*	**770.15**	+T
1688	Total mesorectal excision with colo-anal anastomosis and defunctioning enterostomy or colostomy		*445*	**14,667.20**	*356*	**11,733.76**	*8*	**1232.24**	+T
1743	Needle biopsy of liver		*30.3*	**998.69**	*30.3*	**998.69**	*3*	**462.09**	+T
1744	Extensive debridement, haemostasis and packing of liver wound or injury		*483.8*	**15,946.05**	*387.04*	**12,756.84**	*13*	**2002.39**	+T
1745	Biopsy of liver by laparotomy		*125*	**4,120.00**	*120*	**3,955.20**	*4*	**616.12**	+T
1747	Drainage of liver abscess or cyst		*179.1*	**5,903.14**	*143.28*	**4,722.51**	*7*	**1078.21**	+T
1749	Hemi-hepatectomy: Right		*564*	**18,589.44**	*451.2*	**14,871.55**	*9*	**1386.27**	+T
1751	Hemi-hepatectomy: Left		*521.1*	**17,175.46**	*416.88*	**13,740.36**	*9*	**1386.27**	+T
1753	Partial or segmental hepatectomy		*378*	**12,458.88**	*302.4*	**9,967.10**	*9*	**1386.27**	+T
1757	Simple suture of liver wound or injury		*214.2*	**7,060.03**	*171.36*	**5,648.03**	*9*	**1386.27**	+T
1758	Complex suture of liver wound or injury, including hepatic artery ligation Cannot be used with tariff code 1757		*296.6*	**9,775.94**	*237.28*	**7,820.75**	*13*	**2002.39**	+T
1767	Reconstruction of common bile duct		*371.7*	**12,251.23**	*297.36*	**9,800.99**	*6*	**924.18**	+T

1778	Endoscopic Retrograde Cholangiopancreatography (ERCP): Endoscopy + Catheterisation of pancreas duct or choledochus		*105.9*	**3,490.46**	*105.9*	**3,490.46**	*4*	**616.12**	+T
1791	Local, partial or subtotal pancreatectomy		*351.3*	**11,578.85**	*281.04*	**9,263.08**	*8*	**1232.24**	+T
1815	Drainage of other intraperitoneal abscess (excluding appendix abscess): Transabdominal May be used with tariff code 1637 if appropriate.		*248.4*	**8,187.26**	*198.72*	**6,549.81**	*5*	**770.15**	+T
1817	Drainage of intraperitoneal abscess (excluding appendix abscess) Transrectal drainage of a pelvic abscess		*75*	**2,472.00**	*75*	**2,472.00**	*4*	**616.12**	+T
2711	Electro-encephalogram (EEG): 20-40 minutes record: Equipment cost for taking of record (Technical component) (refer to tariff code 2712 for interpretation and report)		*105.6*	**3,480.58**	*105.6*	**3,480.58**			
2712	Clinical interpretation and report of tariff code 2711: Electro-encephalogram (EEG): 20-40 minutes record (Professional component)		*16.6*	**547.14**	*16.6*	**547.14**			
2714	Cisternal or lateral cervical (C1-C2) puncture: Without injection - stand-alone procedure (Replaces tariff code 2731)		*32*	**1,054.72**	*32*	**1,054.72**	*5*	**770.15**	+T
2747	Burr hole(s): Ventricular puncture, includes injection of gas, contrast media, dye or radioactive material.		*223.8*	**7,376.45**	*179.04*	**5,901.16**	*8*	**1232.24**	+T
2753	Burr hole(s). Includes evacuation and/or drainage of haematoma: Extradural or subdural		*379.4*	**12,505.02**	*303.52*	**10,004.02**	*9*	**1386.27**	+T
2755	Burr hole(s): Includes aspiration of haematoma or cyst, intracerebral (total procedure).		*369.9*	**12,191.90**	*295.92*	**9,753.52**	*9*	**1386.27**	+T
2757	Brain abscess		*402.8*	**13,276.29**	*322.24*	**10,621.03**	*9*	**1386.27**	+T
2767	Suture Brachial Plexus (see also tariff codes 2837 and 2839)		*379*	**12,491.84**	*303.2*	**9,993.47**	*6*	**924.18**	+T
2769	Suture: Large nerve: Primary		*297.7*	**9,812.19**	*238.16*	**7,849.75**	*5*	**770.15**	+T
2773	Suture: Digital nerve: Primary		*199*	**6,559.04**	*159.2*	**5,247.23**	*3*	**462.09**	+T
2777	Nerve graft: Simple		*309*	**10,184.64**	*247.2*	**8,147.71**	*4*	**616.12**	+T
2825	Excision: Neuroma: Peripheral		*213*	**7,020.48**	*170.4*	**5,616.38**	*3*	**462.09**	+T
2827	Transposition of ulnar nerve		*170*	**5,603.20**	*136*	**4,482.56**	*3*	**462.09**	+T
2831	Neurolysis: Major Cannot be used with tariff code 2829		*141*	**4,647.36**	*120*	**3,955.20**	*3*	**462.09**	+T
2833	Neurolysis: Digital		*141*	**4,647.36**	*120*	**3,955.20**	*3*	**462.09**	+T
2859	Depressed skull fracture: Elevation of fracture, compound or comminuted, extradural (total procedure)		*377.9*	**12,455.58**	*302.32*	**9,964.47**	*9*	**1386.27**	+T
2860	Depressed skull fracture: Elevation of fracture, simple, extradural (total procedure)		*307.1*	**10,122.02**	*245.68*	**8,097.61**	*9*	**1386.27**	+T
2862	Depressed skull fracture: Elevation of fracture with repair of dura and/or debridement of brain (total procedure) Replaces tariff code 2861		*455.1*	**15,000.10**	*364.08*	**12,000.08**	*11*	**1694.33**	+T
2863	Cranioplasty: Skull defect =<5 cm diameter: With/without prosthesis		*309.1*	**10,187.94**	*247.28*	**8,150.35**	*9*	**1386.27**	+T
2905	Craniotomy with elevation of bone flap: Excision of epileptogenic focus without electrocorticography during surgery		*489*	**16,117.44**	*391.2*	**12,893.95**	*11*	**1694.33**	+T
2906	Craniotomy: Skull based repair of encephalocele (total procedure)		*493.5*	**16,265.76**	*394.8*	**13,012.61**	*11*	**1694.33**	+T
2972	Narco-analysis (maximum of 3 sessions per treatment) - per session						*24*	**791.04**	

2973	Psychometry by Psychiatrist (specify examination) - per session (maximum of 3 sessions per examination)						*24*	**791.04**	
3013	Sensorimotor examination: With multiple measurements of ocular deviation; one or both eyes (e.g. restrictive or paretic muscle with diplopia) with interpretation and report, for patients over 7 years of age		*12*	**395.52**	*12*	**395.52**			
3123	Insertion of intra-corneal or intrascleral prosthesis for refractive surgery		*470.8*	**15,517.57**	*376.64*	**12,414.05**	*6*	**924.18**	+T
3205	External ear canal: Removal of foreign body: Under general anaesthetic Cannot be used with tariff code 3204		*21*	**692.16**	*21*	**692.16**	*4*	**616.12**	+T
3209	Bilateral myringotomy		*46*	**1,516.16**	*46*	**1,516.16**	*4*	**616.12**	+T
3211	Unilateral myringotomy with insertion ventrilation tube		*38*	**1,252.48**	*38*	**1,252.48**	*4*	**616.12**	+T
3299	Manipulation large joint under general anaesthetic-Anasthetic: Knee/Shoulder		*14*	**461.44**			*3*	**462.09**	Hip+T
3300	Manipulation of large joints without anaesthetic		*		*	*			

CLINICAL PATHOLOGY

		Pathologist		**Other Specialists and General Practitioners**	
Code	**Code Description**	**U**	**R**	**U**	**R**
4086	Plasma Lactate	*9.32*	**319.77**	*6.59*	**226.10**
4085	Lipase	*3.01*	**103.27**	*2.14*	**73.42**

NEW CONSULTATIVE SERVICES AS FROM 01 APRIL 2025 (GENERAL PRACTITIONER and ALL SPECIALISTS)

I. CONSULTATIVE SERVICES

		Specialist		General Practitioner		Anaesthetic		
Code	**Code Description**	**U**	**R**	**U**	**R**	**U**	**R**	**T**
	OUT OF HOSPITAL CONSULTATION							
0190	New and established patient: Consultation/visit of established patient of an **average duration and/or complexity**. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0174 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to anaesthetic structure	*17*	**570.86**	*15*	**503.70**	*16.5*	**554.07**	

0191	New and established patient: Consultation/visit of new or established patient of a **moderately above average** duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0174 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to anaesthetic structure	*32*	**1,074.56**	*30*	**1,007.40**	*31.5*	**1,057.77**	
	HOSPITAL CONSULTATION / VISIT							
0173	First hospital consultation/visit of an **average** duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure)	*16.5*	**543.84**	*15*	**494.40**	*16.5*	**543.84**	

0174	First in hospital consultation/visit: Consultation/visit of a **moderately above average duration** and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient	*31.5*	**1,038.24**	*30*	**988.80**	*31.5*	**1,038.24**	
0175	First hospital consultation/visit of **long duration and/or high** complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure)	*36*	**1,186.56**	*33*	**1,087.68**	*36*	**1,186.56**	
	ADD-ON CONSULTATION SERVICES							
0146	Emergency or unscheduled consultation/visit at the doctor's home or rooms: ADD to items 0164-0169 or 0190-0192 or 0173-0175 as appropriate. **(General Rule B refers)**	*8*	**263.68**	*8*	**263.68**			

	GENERAL							
0199	Completion of chronic medication forms by medical doctors with or without the physical presence of the patient requested by or on behalf of a third party funder or its agent	*21.43*	**706.33**	*21.4*	**706.33**			

AMENDMENT FOR PHYSIOTHERAPY GAZETTE, NOTICE 3055 PUBLISHED ON 17 MARCH 2025, NO: 52328

PHYSIOTHERAPY TARIFF OF FEES AS FROM 1 APRIL 2025 (PRACTICE TYPE 072)	
General Rules	
Rule	**Rule Description**
001	Unless timely steps are taken (at least two hours) to cancel an appointment for a consultation the relevant consultation fee shall be payable by the employee.
003	Patients Hospitalised following an emergency injury on duty will not require pre-authorisation for rehabilitation services. However, the Physiotherapist must submit monthly progress reports, a Referral letter from the Medical Doctor and an initial treatment plan with the invoice to the Compensation Fund. All the cases are subject to case management.
004	AM and PM treatment sessions, applicable only to hospitalised patients, should be specified and medically motivated for on the Annexure F (Motivation for twice a day Physiotherapy).
005	Out - patients will be allowed up to 20 sessions without pre-authorization. This includes Return to work rehabilitation. If further treatment is necessary after a series of 20 treatment sessions for the same condition, the Physiotherapist must submit a motivation with treatment plan to the Compensation Fund for authorisation with a recent referral from the treating doctor. The Physiotherapist must submit monthly progress report to the CF. Modifier 0015 must be quoted.
006	"After hour treatment" shall mean all physiotherapy performed where emergency treatment and /or essential continuation of care is required after working hours, before 08:00 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 08:00 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 percent. Modifier 0006 must then be quoted after the appropriate tariff code to indicate that this rule is applicable. Where emergency treatment is provided: a. during working hours, and the provision of such treatment requires the practitioner to leave his or her practice to attend to the patient in hospital; or b. after working hours, the fee for such visits shall be the total fee plus 50%. a. "emergency treatment" means a bona fide, justifiable emergency physiotherapy procedure, where failure to provide the procedure immediately would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy; and b. "working hours" means 8h00 to 17h00, Monday to Friday.
007	The Physiotherapist shall submit his / her account for treatment directly to the Fund using available electronic means.

008	When an employee is referred for physiotherapy treatment after a surgical procedure, a new treatment plan needs to be provided to the Fund.
009	When more than one condition requires treatment and each of these conditions necessitates an individual treatment, they shall be charged as individual treatments. Full details of the nature of the treatments and the diagnosis or diagnostic codes shall be stated. Modifier 0009 must be quoted.
010	When the treatment times of two completely separate and different conditions overlap, the fee shall be the full fee for one condition and 50% of the fee for the second condition. Both conditions must be specified. Modifier 0010 must then be quoted after the appropriate code number to indicate that this rule is applicable.
011	Cost of external material used in therapy. It is recommended that, when such items are used during a procedure or issued to a patient on discharge will only be reimbursed if the appropriate code is supplied on the account (72939).
012	An invoice for services rendered will be assessed and added without VAT. VAT is then calculated and added to the final payment amount.
013	When a physiotherapist performs treatment away from the treatment rooms, travelling costs being **more than 5 kilometres**, to be charged at R4,84 per km for each kilometre travelled in own car e.g. 19 km total = 19X R4,84 = R91.96. If more than one employee is attended to during the course of a trip, the full travelling expenses must be pro rata between the relevant employees (the physiotherapist will claim for one trip). A Physiotherapist is not entitled to charge any travelling expenses or travelling time to his / her rooms. Modifier 0013 must be quoted.
014	Physiotherapy services rendered in a hospital, Modifier 0014 must be quoted after each tariff code.
015	The services of a Physiotherapist shall be approved 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.
	Modifiers
Abbre viation	**Description**
AM	Additional Modifier
IM	Information Modifier
RM	Reduction Modifier

Modifier	Modifier Description
0006	AM: Emergency Modifier - Add 50% of the total fee for the treatment. Refer to Rule 006
0009	AM: Treatment of two separate conditions. Refer to Rule 009
0010	RM: Only 50% of the fee for the second condition may be charged. Refer to rule 010
0013	AM: Travelling costs. Refer to rule 013
0014	IM: Physiotherapy services rendered in hospital patients. Refer to Rule 014
0015	IM: Physiotherapy services rendered as an out-patient. Refer to rule 005

Tariff Codes

Note	Note that only one treatment code may be charged per treatment session (72925 / 72926 / 72327 /72921 /72923 / 72928 / 72927). 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), one relevant rehabilitation code and cost of material code (72939).	
Code	**Code Description**	**Rand**
1.	**Rehabilitation**	
72107	Electro / Cryo / Moist-therapy modality usage for treatment	**170.00**
72501	Rehabilitation where the pathology requires the undivided attention of the Physiotherapist. Duration: 30min. This code can only be claimed once per treatment session	**593.00**
72503	Rehabilitation for Central Nervous System disorders - condition to be clearly stated and fully documented (No other treatment modality may be charged in conjunction with this). Duration: 60min. This code can only be claimed once per treatment session	**1186.21**
72505	Group rehabilitation. Treatment of a patient with disabling pathology in an appropriate facility requiring specific equipment and supervision, without individual attention for the whole treatment session	**400.00**
72606	Physiotherapeutic group rehabilitation (<45 min). Requires the undivided attention of the physiotherapist.	**750.00**
72509	Rehabilitation. Each additional full 15 mins. Where the pathology requires the undivided attention of the physiotherapist. A maximum of two instances of this code may be charged per session. Tariff code 72509 can be added to 72501 and 72503.	**189.72**

2.	Evaluation	Rand
72701	Basic assessment at commencement of care, once per episode of care. It should not be used for each condition. A treatment plan / rehabilitation progress report must be fully documented and submitted at the initiation of treatment. Tariff code 72701 cannot be used with 72702	341.57
72702	Comprehensive assessment at commencement of care, once per episode of care. It should not be used for each condition. A treatment plan / rehabilitation progress report describing what makes the evaluation complex, must be fully documented and submitted at the initiation of treatment. Tariff code 72702 cannot be used with 72701	511.89
72703	One complete re-assessment of a patient's condition during the course of treatment. To be used only once per single Doctor referral. This should be fully documented and a rehabilitation progress report provided to the Compensation Fund. Rule 015 applies.	170.34
72706	Report Writing. To be used to motivate for therapy and/or give a progress report.	204.12

AMENDMENT FOR OCCUPATIONAL THERAPY GAZETTE, NOTICE 3048 PUBLISHED ON 17 MARCH 2025, NO: 52321

OCCUPATIONAL THERAPY TARIFF OF FEES AS FROM 1 APRIL 2024 (PRACTICE TYPE 066)	
General Rules	
Rule	**Rule Description**
001	Unless timely steps are taken (at least two hours) to cancel an appointment for a consultation the relevant consultation fee shall be payable by the employee.
003	The service of an occupational therapist shall be available only on written referral by a treating doctor. The medical treating doctor must clearly indicate the reason for the referral, relationship to the original injury. The referral may be on the service providers (Occupational therapy practice) letterhead, provided it is signed by the referring doctor.
004	Newly Hospitalised patients **will not require pre-authorisation** for rehabilitation services. However, the Occupational Therapist must submit monthly progress reports, a Referral letter from the Medical Doctor and an initial treatment plan with the invoice to the Compensation Fund. All the cases are subject to case management.
005	Out - patients will be allowed up to 20 sessions **without pre-authorization**. If further treatment is necessary after a series of 20 treatment sessions for the same condition, the Occupational Therapist must submit a motivation with treatment plan to the Compensation Fund for authorisation with a recent referral from the treating doctor. The Occupational Therapist must submit monthly progress report to the CF. Modifier 0015 must be quoted.
006	"Afterhours treatment" shall mean those emergency treatment sessions performed at night between 18:00 and 07:00 on the following day or during weekends between 13:00 Saturday and 07:00 Monday. Public holidays are treated as Sundays. The fee for all treatment under this rule shall be the total fee for the treatment plus 50 percent. This rule shall apply for all treatment administered in the practitioner's rooms, or at a hospital or private residence (only by arrangement when the patient's condition necessitates it). Modifier 0006 must then be quoted after the appropriate tariff code to indicate that this rule is applicable.
008	The provision of aids or assistive devices shall be charged at cost. Modifier 0008 must be quoted after the appropriate tariff code to show this rule is applicable.
009	Materials used in the construction of orthoses will be charged as per Annexure "A" for the applicable device and pressure garments will be charged as per Annexure "B" for the applicable garment. Modifier 0009 must be quoted after the appropriate tariff code to show that this rule is applicable.

010	Materials used in treatment shall be charged at cost. Modifier 0010 must be quoted after the appropriate tariff code to show that this rule is applicable.
011	When an Occupational Therapist performs treatment away from the treatment rooms, travelling costs being **more than 5 kilometres**, to be charged at R4,84 per km for each kilometre travelled in own car e.g. 19 km total = 19X R4,84 = R91.96.If more than one employee is attended to during the course of a trip, the full travelling expenses must be pro rata between the relevant employees (the Occupational therapist will claim for one trip). An Occupational therapist is not entitled to charge any travelling expenses or travelling time to his / her rooms. Modifier 0011 must be quotedNote: POEs to be attached : work visit attendance register, work visit report and google map intake from the practice to the destination.
014	Only one Evaluation Procedure code may be billed per treatment session and utilised as per the rule of the individual code
016	Occupational Therapists, Physiotherapists and Chiropractors may not provide simultaneous treatment at the same time on a day, but may treat the same patient. (Multidisciplinary goals must be considered and the best placed service provider to achieve the rehabilitation goal must address that specific goal).
020	The use of the work hardening codes must match the rehabilitation plan provided by the Occupational Therapist and should clearly indicate how the work hardening program will be included in their rehabilitation program and graded return to work plan. The therapist may provide a maximum of 10 sessions of group work hardening intervention per patient, where a maximum of 5 patients are treated simultaneously in the same treatment area and each patient is set up with customised work simulation tasks. Each session to take place on a separate day and to be of duration of at least 120 minutes. If more than 10 sessions are necessary the authorization must be requested from the Fund. **Note: This treatment must be authorized by the Fund.** The Occupational Therapist should add the confirmation of employment which must accompany the pre-authorization request for work hardening.

Modifiers	
Modifier	**Modifier Description**
0017	Services rendered to hospital **in-patients**: Quote modifier 0017 on all invoices for services performed on hospital in-patients.
0018	Services rendered to **out-patients**: Quote modifier 0018 on all invoices for services performed on hospital outpatients.
0006	Emergency modifier: add 50% of the total fee for treatment. Refer to Rule 006
0008	Aids or assistive devices should be charged at cost. Refer to Rule 008

0009	Materials used for construction of orthoses or pressure garments, **consumables for dressing, wound care/oedema management & scar management** should be charged as per Annexures "A, B and C" for the applicable device and pressure garments. See Annexures "A and B" for non-standard products. Refer to Rule 009 NB: Consider this addition consumables for dressing, wound care/oedema management & scar management
0010	Materials used in treatment should be charged at cost. Refer to Rule 010
0011	Travelling cost according to CF agreed rates. Refer to Rule 011.
0012	A detailed report of the work assessment with signatures of the employer and the injured worker shall be submitted to the Compensation Commissioner with the invoice.

AMENDMENT FOR SOCIAL WORKER GAZETTE, NOTICE 3054 PUBLISHED ON 17 MARCH 2025, NO: 52327

SOCIAL WORKER SERVICES TARIFF OF FEES AS FROM 1 APRIL 2025 (PRACTICE TYPE 089)	
General Rules	
Rule	**Rule Description**
001	Social Workers services account must be accompanied by a referral letter from the treating principal doctor indicating the condition of the employee and the need for such services. An overall event limit of ten (10) social worker consultations including group therapy is allowed and only one session /visit is allowed per day. More than 10 social worker consultations sessions will require pre-authorisation.
007	**a.** An emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment/ therapy and/or an operation. If the treatment is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death. **b.** "Emergency treatment" means a bona fide, justifiable emergency social work service, where failure to provide the service immediately would result in serious or irreparable psychological or functional impairment. **c.** "working hours" means 8h00 to 17h00, Monday to Friday. Modifier 0003 must be quoted after the appropriate tariff code to indicate that this rule is applicable. **Where emergency treatment is provided:** **a.** During working hours, and the provision of such treatment requires the Practitioner to leave their practice to attend to the patient at another venue; or **b.** After working hours; the fee for such visits shall be the total fee plus 50%.
008	Compilation of reports: Reports are required after every consultation, counselling and/or therapy including group therapy.
009	Where a practitioner performs treatment away from the treatment rooms, travelling costs being **more than 5 kilometres** in total to be charged at R4,84 per km for each kilometre travelled in own car e.g. 19 km total = 19X R4,84 = R91.96. If more than one employee is attended to during the course of a trip, the full travelling expenses must be pro-rata between the relevant employees (the practitioner will charge for one trip). A practitioner is not entitled to charge any travelling expenses or travelling time to his/her treatment rooms. Refer to Modifier 0009

Modifiers	
Modifier	**Modifier Description**
0003	Emergency consultation: Add 50% of the total fee for the treatment. Use of the Modifier should always be accompanied by a motivation.
0021	Services rendered to hospital inpatients: Quote Modifier 0021 on all invoices for services performed on hospital inpatients.
0022	Services rendered at patient's residence: Quote Modifier 0022 on all invoices for services performed at the patient's residence. Refer to Rule 009
0009	Travelling costs. Refer to Rule 009

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