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Contents

DEPARTMENT OF EMPLOYMENT AND LABOUR

NOTICE 922 OF 2022

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 & 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 2022**.

2. Medical Tariffs increase for **2022 is 0%.**

3. The fees appearing in the Schedule are applicable in respect of all services rendered on or after **1 April 2022** and **Exclude 15% Vat.**

MR TW NXESI MP
MINISTER OF EMPLOYMENT AND LABOUR
DATE: 03/03/2022

GENERAL INFORMATION

THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

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

In terms of section 42 of the Compensation for Occupational Injuries and Diseases Act, the Compensation Fund may refer an injured employee to a specialist medical practitioner designated by the Director General for a medical examination and report. Special fees are payable when this service is requested.

In terms of section 76,3(b) of the Compensation for Occupational Injuries and Diseases Act, no amount in respect of medical expenses shall be recoverable from the employee.

In the event of a change of medical practitioner attending to a case, the first doctor in attendance will, except where the case is transferred to a specialist, be regarded as the principal. **To avoid disputes regarding the payment for services rendered, medical practitioners should refrain from treating an employee already under treatment by another doctor without consulting / informing the first doctor.** As a general rule, changes of doctor are not favoured by the Compensation Fund, unless sufficient reasons exist.

According to the National Health Act no 61 of 2003, Section 5, a health care provider may not refuse a person emergency medical treatment. Such a medical service provider should not request the Compensation Fund to authorise such treatment before the claim has been submitted to and accepted by the Compensation Fund. **Pre-authorisation of treatment is not possible and no medical expense will be approved if liability for the claim has not been accepted by the Compensation Fund.**

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

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

The tariff amounts published in the tariff guides to medical services rendered in terms of the Compensation for Occupational Injuries and Diseases Act do not include VAT. All 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.

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

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

CLAIMS WITH THE COMPENSATION FUND ARE PROCESSED AS FOLLOWS

1. New claims are registered by the Employers and the Compensation Fund and the **employer views the claim number allocated online.** The allocation of a claim number by the Compensation Fund, does not constitute acceptance of liability for a claim, but means that the injury on duty has been reported to and registered by the Compensation Commissioner. Enquiries regarding claim numbers should be directed to the employer and not to the Compensation Fund. The employer will be in the position to provide the claim number for the employee as well as indicate whether the claim has been accepted by the Compensation Fund.

2. If a claim is **accepted** as a COIDA claim, **reasonable medical expenses** will be paid by the Compensation Commissioner.

3. If a claim is **rejected (repudiated)**, medical expenses for services rendered will not be paid by the Compensation Commissioner. The employer and the employee will be informed of this decision and the injured employee will be liable for payment.

4. If **no decision** can be made regarding acceptance of a claim due to inadequate information, the outstanding information will be requested and upon receipt, the claim will again be adjudicated on. Depending on the outcome, the 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 lack of forthcoming information.

BILLING PROCEDURE

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

   1.1 Medical reports should always have a clear and detailed clinical description of injury.
   1.2 A progress medical report covering a period of 30 days will be required, with an exception where a procedure was performed during that period.
   1.3 In a case where a procedure is done, an operation report is required.
   1.4 Only one medical report is required when multiple procedures are done on the same service date.
   1.5 Service providers are required to keep original documents (i.e medical reports, invoices) and these should be made available to the Compensation Commissioner on request.
   1.6 Referrals to another medical service provider should be indicated on the medical report.

2. Medical invoices should be switched to the Compensation Fund using the attached format. - Annexure D.

   2.1. Subsequent invoice must be electronically switched. It is important that all requirements for the submission of invoice, including supporting information, are submitted.
   2.2. Manual documents for medical refunds should be submitted to the nearest labour centre.

3. The status of invoices /claims can be viewed on the Compensation Fund claims system. If invoices are still outstanding after 60 days following submission, the service provider should complete an enquiry form, W.Cl 20, and submit it ONCE to the Provincial office/Labour Centre. All relevant details regarding Labour Centres are available on the website www.labour.gov.za .

4. If an invoice has been partially paid with no reason indicated on the remittance advice, an enquiry should be made with the nearest processing labour centre. The service provider should complete an enquiry form, W.Cl 20, accompanied by the original invoice with unpaid services clearly indicated, and submit it ONCE to the Provincial office/Labour Centre. All relevant details regarding Labour Centres are available on the website www.labour.gov.za .

5. Details of the employee's medical aid and the practice number of the referring practitioner must not be included in the invoice.

5.1 If a medical service provider claims an amount less than the published tariff amount for a code, the Compensation Fund will only pay the claimed amount and the short fall will not be paid.

6. Service providers should not generate the following:

6.1 Multiple invoices for services rendered on the same date i.e one invoice for medication and second invoices for other services.

6.2 Accumulative invoices – submit a separate invoice for every month.

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

MINIMUM REQUIREMENTS FOR INVOICES RENDERED

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

- Compensation Fund claim number
- Name of employee and ID number
- Name of employer and registration number if available
- DATE OF ACCIDENT (not only the service date)
- Service provider's **invoice number**
- The practice number (changes of address should be reported to BHF)
- VAT registration number (VAT will not be paid if a VAT registration number is not supplied on the invoice)
- Date of service (the actual service date must be indicated: the invoice date is not acceptable)
- Item codes according to the officially published tariff guides
- Amount claimed per item code and total of the invoice
- It is important that all requirements for the submission of invoices are met, including supporting information, e.g:
    - All pharmacy or medication invoices must be accompanied by the original scripts
    - The referral letter from the treating practitioner must accompany the medical service providers' invoice.

COMPENSATION FUND MEDICAL SERVICE PROVIDERS REGISTRATION REQUIREMENTS

Medical service providers treating COIDA patients must comply with the following requirements before submitting medical invoices to the Compensation Fund:

- Medical Service Providers must register with the Compensation Fund as a Medical Service Provider.
- Render medical treatment to in terms of COIDA Section 76 (3) (b).
- Submit Proof of registration with the Board of Healthcare Funders of South Africa.
- Submit an applicable dispensing licence on registration as a medical service provider.
- Submit SARS Vat registration number document on registration.
- A certified copy of the MSP's Identity document not older than three months.
- Proof of address not older than three months.
- Submit medical invoices with gazetted COIDA medical tariffs, relevant ICD10 codes and additional medical tariffs specified by the Fund when submitting medical invoices.
- All medical invoices must be submitted with invoice numbers to prevent system rejections. Duplicate invoices should not be submitted.
- Provide medical reports and invoices within a specified time frame on request by the Compensation Fund in terms of Section 74 (1) and (2).
- Submit the following additional information on the Medical Service Provider letterhead, Cell phone number, Business contact number, Postal address, Email address. The Fund must be notified in writing of any changes in order to effect necessary changes on the systems.
- The name of the switching house that submit invoices on behalf of the medical service provider. The Fund must be notified in writing when changing from one switching house to another.

All medical service providers will be subjected to the Compensation Fund vetting processes.

The Compensation Fund will withhold payments if medical invoices do not comply with minimum submission and billing requirements as published in the Government Gazette.

REQUIREMENTS FOR SWITCHING MEDICAL INVOICES WITH THE COMPENSATION FUND

The switching provider must comply with the following requirements:

1. Registration requirements as an employer with the Compensation Fund.
2. Host a secure FTP server to ensure encrypted connectivity with the Fund.
3. Submit and complete a successful test file before switching the invoices.
4 Validate medical service providers' registration with the Health Professional Council of South Africa.
5 Validate medical service providers' registration with the Board of Healthcare Funders of South Africa.
5. Ensure elimination of duplicate medical invoices before switching to the Fund.
6. Invoices submitted to the Compensation Fund must have Gazetted COIDA Tariffs that are published annually and comply with minimum requirements for submission of medical invoices and billing requirements.
7. File must be switched in a gazetted documented file format published annually with COIDA tariffs.
8. Single batch submitted must have a maximum of 100 medical invoices.
9. File name must include a sequential batch number in the file naming convention.
10. File names to include sequential number to determine order of processing.
11. Medical Service Providers will be subjected to Compensation Fund vetting processes.
12. Provide any information requested by the Fund.
13. The switching provider must sign a service level agreement with the Fund.
14. Third parties must submit power of attorney.
15. Only Pharmacies should claim from the Nappi codes file.

Failure to comply with the above requirements will result in deregistration of the switching house.

MSP's PAID BY THE COMPENSATION FUND	
Discipline Code :	**Discipline Description :**
4	Chiropractors
9	Ambulance Services - advanced
10	Anesthetists
11	Ambulance Services - Intermediate
12	Dermatology
13	Ambulance Services - Basic
14	General Medical Practice
15	General Medical Practice
16	Obstetrics and Gynecology (work related injuries)
17	Pulmonology
18	Specialist Physician
19	Gastroenterology
20	Neurology
22	Psychiatry
23	Rediation/Medical Oncology
24	Neurosurgery
25	Nuclear Medicine
26	Ophthalmology
28	Orthopedics
30	Otorhinolaryngology
34	Physical Medicine
36	Plastic and Reconstructive Surgery
38	Diagnostic Radiology
39	Radiographers
40	Radiotherapy/Nuclear Medicine/Oncologist
42	Surgery Specialist
44	Cardio Thoracic Surgery
46	Urology
49	Sub-Acute Facilities
52	Pathology
54	General Dental Practice
55	Mental Health Institutions
56	Provincial Hospitals
57	Private Hospitals
58	Private Hospitals
59	Private Rehab Hospital (Acute)
60	Pharmacies
62	Maxillo-facial and Oral Surgery
64	Orthodontics
66	Occupational Therapy
70	Optometrists
72	Physiotherapists
75	Clinical technology (Renal Dialysis only)
76	Unattached operating theatres / Day clinics
77	Approved U O T U / Day clinics
78	Blood transfusion services
82	Speech therapy and Audiology
84	Dieticians
86	Psychologists
87	Orthotists & Prosthetists
88	Registered nurses

89	Social workers
90	Manufacturers of assisstive devices

	AMBULANCE TARIFF OF FEES AS FROM 1 APRIL 2022
	GENERAL RULES
RULE	**DESCRIPTION**
001	Road ambulances: Long distance claims (items 111, 129 and 141) will be rejected **unless the distance travelled with the patient** is reflected. Long distance charges may not include item codes 102, 125,127,131 or 133
002	No after hours fees may be charged.
003	Road ambulances: Item code 151 (resuscitation) may only be charged for services provided by a second vehicle (either ambulance or response vehicle) and shall be accompanied by a motivation. Disposables and drugs used are included unless specified as additional cost items (see below).
004	A **BLS** (Basic Life Support) practice (Pr. No. starting with 13) may **not** charge for ILS (Intermediate Life Support) or ALS (Advanced Life Support); an **ILS** practice (Pr. No. starting with 11) may **not** charge for ALS. An **ALS** practice (Pr. No. starting with 09) **may charge for all codes.**
005	A second patient is transferred at 50% reduction of the basic call cost. Rule 005 MUST be quoted if a second patient is transported in any vehicle or aircraft in addition to another patient.
006	Guidelines for information required on each COIDA ambulance account: **Road and air ambulance accounts** • Name and ID number of the employee · Diagnosis of the employee's condition · Summary of all equipment used if not covered in the basic tariff · Name, practice number and HPCSA registration number of the medical doctor · Response vehicle: details of the vehicle driver and the intervention undertaken on patient · Place and time of departure and arrival at the destination as well as the exact distance travelled (Air ambulance: exact time travelled from base to scene, scene to hospital and back to base) **Definitions of Ambulance Patient Transfer** Basic Life Support - A callout where the patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered Basic Ambulance Assistant whilst the patient is in transit. Intermediate Life Support - A callout where the patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered Ambulance Emergency Assistant (AEA), e.g. initiating IV therapy, nebulisation etc. whilst the patient is in transit. **NOTES** • If a hospital or doctor requires a paramedic to accompany the patient on a transfer in the event of the patient needing ALS / ILS intervention, the doctor requesting the paramedic must write a detailed motivational letter in order for ALS / ILS fees to be charged for the transfer of the patient. • In order to bill an Advanced Life Support call, a registered Advanced Life Support provider must have examined, treated and monitored the patient whilst in transit to the hospital. • In order to bill an Intermediate Life Support call, a registered Intermediate Life Support provider must have examined, treated and monitored the patient whilst in transit to the hospital. • When an ALS provider is in attendance at a callout but does not do any interventions on the patient at an ALS level, the billing should be based on a lesser level, dependent on the care given to the patient. (E.g. if a paramedic sites an IV line or nebulises the patient with a B-agonist which falls within the scope of practice of an AEA, the call • Where the management undertaken by a paramedic or AEA falls within the scope of practice of a BAA the call must be billed at a BLS level. **Please Note** • The amounts reflected in the COIDA Tariff Schedule for each level of care are inclusive of any disposables (except for pacing pads, Heimlich valves, high capacity giving sets, dial-a-flow and intra-osseous needles) and drugs used in the management of the patient, as per the attached nationally approved medication protocols. • Haemaccel and colloid solution may be charged for separately. • **An ambulance is regarded by the Compensation Fund as an emergency vehicle that administers emergency care and transport to those employees with acute injuries and only such emergency care and transport will be paid for by the Compensation Fund. A medical emergency is any condition where death or irreparable harm to the patient will result if there are undue delays in receiving appropriate medical treatment.**

	• **Claims for transfers between hospitals or other service providers must be accompanied by a motivation from the attending doctor who requested such transport. The motivation should clearly state the medical reasons for the transfer. Motivation must also be provided if ILS or ALS is needed and it should be indicated what specific medical assistance is required on route. This is also applicable for air ambulances.**
	• **Transportation of an employee from his home to a service provider, this includes outpatients between two service providers, if not in an emergency situation, is not payable. In emergency cases such transport should be motivated for and the attending doctor should indicate what specific medical assistance is required on route.** **Claims for the transport of a patient discharged home will only be accepted if accompanied by a written motivation from the attending doctor who requested such transport, clearly stating the medical reasons why an ambulance is required for such transport. It should be indicated what specific medical assistance the patient requires on route. If such a request is approved only BLS fees will be payable. Transport of a patient for any other reason than a MEDICAL reason, (e.g. closer to home, do not have own transport) will not be entertained.**
	RESPONSE VEHICLES
	Response vehicles only - Advance Life Support (ALS) **A clear distinction must be drawn between an acute primary response and a booked call.**
1.	An Acute Primary Response is defined as a response to a call that is received for medical assistance to an employee injured at work or in a public area e.g. motor vehicle accident. If a **response vehicle** is dispatched to the scene of the emergency and the patient is in need of advanced life support and such support is rendered by the ALS Personnel e.g. CCA or National Diploma, the response vehicle service provider shall be entitled to bill item 131 for such service. However, the same or any other ambulance service provider which is then **transporting** the patient shall not be able to levy a bill as the cost of transportation is included in the ALS fee under item 131. Furthermore,
2.	In the event of an response vehicle service provider rendering ALS and not having its own ambulance available in which to transport the patient to a medical facility, and makes use of another ambulance service provider, only the bill for the response vehicle service may be levied as the ALS bill under items 131. Since the ALS tariff already includes transportation, the response vehicle service provider is responsible for the bill for the other ambulance service provider, which will be levied at a BLS rate. This ensures that there is **only one bill levied per patient.**
3.	Should a response vehicle go to a scene and not render any ALS treatment then a bill may not be levied for the said response vehicle.
4.	Notwithstanding 3, item 151 applies to all ALS resuscitation as per the notes in this schedule.
	Response vehicle only - Intermediate Life Support (ILS) **A clear definition must be drawn between the acute primary response and a booked call.**
4.1	An Acute Primary Response is defined as a response to a call that is received for medical assistance to an employee injured at work or in a public area e.g. motor vehicle accident. If an ILS **response vehicle** is dispatched to the scene of the emergency and the patient is in need of intermediate life support and such support is rendered by the ILS Personnel e.g. AEA, the response vehicle service provider shall be entitled to bill item 125 for such service. However, the same or any other ambulance service provider which is then **transporting** the patient shall not be able to levy a bill as the cost of transportation is included in the ILS fee under item 125. Furthermore, the ILS
4.2	In the event of an response vehicle service provider rendering ILS and not having its own ambulance available in which to transport the patient to a medical facility, and makes use of another ambulance service provider, only the bill for the response vehicle service may be levied as the ILS bill under item 125. Since the ILS tariff already includes transportation, the response vehicle service provider is responsible for the bill for the other ambulance service provider, which will be levied at a BLS rate. This ensures that there is **only one bill levied per patient.**
4.3	Should a response vehicle go to a scene and not render any ILS treatment then a bill may not be levied for the said response vehicle.
5	**NATIONALLY APPROVED MEDICATION WHICH MAY BE ADMINISTERED BY HPCSA-REGISTERED AMBULANCE PERSONNEL ACCORDING TO HPCSA-APPROVED PROTOCOLS** **Registered Basic Ambulance Assistant Qualification** • Oxygen ·Entonox · Oral Glucose · Activated charcoal **Registered Ambulance Emergency Assistant Qualification** As above, plus Intravenous fluid therapy Intravenous dextrose 50% B2 stimulant nebuliser inhalant solutions (Hexoprenaline, Fenoterol, Sulbutamol)

	Registered Paramedic Qualification As above, plus · Oral Glyceryl Trinitrate · Clopidegrol · Endotracheal Adrenaline and Atropine · Intravenous Adrenaline, Atropine, Calcium, Corticosteroids, Hydrocortisone, · Lignocaine, Naloxone, Sodium Bicarbonate 8,5%, Metaclopramide · Intravenous Diazepam, Flumazenil, Furosemide, Glucagon, Lorazepam, · Magnesium, Midazolam, Thiamine, Morphine, Promethazine · Pacing and synchronised cardioversion ***PLEASE NOTE*: *VAT cannot be added on the following codes: 102, 103, 111, 125, 127, 129, 131, 133 and 141.*** ***VAT will only be paid with confirmation of a VAT registration number on the account.***			
CODE	**DESCRIPTION OF SERVICE**	**13**	**11**	**9**
1	**BASIC LIFE SUPPORT**			
	(Rule 001: Metropolitan area and long distance codes may not be claimed simultaneously)			
	Metropolitan area (less than 100 kilometres) *No account may be levied for the distance back to the base in the*			
***102**	Up to 60 minutes	**2496.63**	**2496.63**	**2496.63**
***103**	Every 15 minutes (or part thereof) thereafter, where specially motivated	**624.90**	**624.90**	**624.90**
	Long distance (more than 100 km)			
***111**	Per km **DISTANCE TRAVELLED WITH PATIENT**	**31.10**	**31.10**	**31.10**
112	Per km **NON PATIENT CARRYING KILOMETRES** (With maximum of 400 km)	**13.98**	**13.98**	**13.98**
2	**INTERMEDIATE LIFE SUPPORT** ***(Rule 001: metropolitan area and long distance codes may not be claimed simultaneously)***			
	Metropolitan area (less than 100 kilometres) *No account may be billed for the distance back to the base in the*			
***125**	Up to 60 minutes	--	**3299.43**	**3299.43**
***127**	Every 15 minutes (or part thereof) thereafter, where specially motivated		**843.37**	**843.37**
	Long distance (more than 100 km)			
***129**	Per km **DISTANCE TRAVELLED WITH PATIENT**	--	**42.12**	**42.12**
130	Per km **NON PATIENT CARRYING KILOMETRES** (With maximum of 400 km)	--	**13.98**	**13.98**
	** VAT Exempted codes*			
3.	**ADVANCED LIFE SUPPORT / INTENSIVE CARE UNIT** ***(Rule 001: Metropolitan area and long distance codes may not be claimed simultaneously)***			
	Metropolitan area (less than 100 kilometres) *No account may be billed for the distance back to the base in the*			
***131**	Up to 60 minutes	--	--	**5236.31**
***133**	Every 15 minutes (or part thereof) thereafter, where specially motivated	--	--	**1709.36**
	Long distance (more than 100 km)			
***141**	Per km **DISTANCE TRAVELLED WITH PATIENT**	--	--	**75.78**
142	Per km **NON PATIENT CARRYING KILOMETRES** With maximum of	--	--	**13.98**
4	**ADDITIONAL VEHICLE OR STAFF FOR INTERMEDIATE LIFE SUPPORT, ADVANCED LIFE SUPPORT AND INTENSIVE CARE**			
151	Resuscitation fee, per incident, for a second vehicle with paramedic and / or other staff (all materials and skills included)	--		**5746.06**

	Note: A resuscitation fee may only be billed for when a second vehicle (response vehicle or ambulance) with staff (including a paramedic) attempt to resuscitate the patient using full ALS interventions. These interventions must include one or more of the following: · Administration of advanced cardiac life support drugs · Cardioversion -synchronised or unsynchronised (defibrillation) · External cardiac pacing · Endotracheal intubation (oral or nasal) with assisted ventilation			
153	Doctor per hour	--		**1651.27**
	Note: Where a doctor callout fee is charged the name, HPCSA registration number and BHF practice number of the doctor must appear on the bill. Medical motivation for the callout must be supplied.			

** VAT Exempted codes*

AEROMEDICAL TRANSFERS

ROTOR WING RATES

DEFINITIONS:

1. Helicopter rates are determined according to the aircraft type.
2. Daylight operations are defined from sunrise to sunset (and night operations from sunset to sunrise).
3. If flying time is mostly in night time (as per definition above), then night time operation rates (type C) should be billed.
4. The call out charge includes the basic call cost plus other flying time incurred. Staff and consumables cost can only be charged if a patient were treated.
5. Should a response aircraft respond to a scene (at own risk) and not render any treatment, a bill may not be levied for the said response.
6. Flying time is billed per minute but a minimum of 30 minutes applies to the payment.
7. A second patient is transferred at 50% reduction of the basic call and flight costs, but staff and consumables costs remain billed per patient, only if the aircraft capability allows for multiple patients. Rule 005 must be quoted on the account.

All published tariffs exclude VAT. VAT can be charged on air ambulances if a VAT registration number is supplied.

AIRCRAFT TYPE A: (typically a single engine aircraft)

HB206L, HB204 / 205, HB407, AS360, EC120, MD600, AS350, A119

AIRCRAFT TYPE B & Ca (DAY OPERATIONS): (typically a twin

BO105, 206CT, AS355, A109

AIRCRAFT TYPE Cb (NIGHT OPERATIONS): (typically a specially equipped craft for night flying)

HB222, HB212 / 412, AS365, S76, HB427, MD900, BK117, EC135, BO105

AIRCRAFT TYPE D (RESCUE)

H500, HB206B, AS350, AS315, FH1100, EC 130, S316

FIXED WING TARIFFS:

DEFINITIONS:

1. Group A must fall within the Cat 138 Ops as determined by the Civil Aviation Authority.
2. Please note that no fee structure has been provided for Group B, as emergency charters could include any form of aircraft. It would be impossible to specify costs over such a broad range. As these would only be used during emergencies when no Group A aircraft are available, no staff or equipment fee should be charged.
3. All published tariffs exclude VAT. VAT can be charged on air ambulances only if a VAT registration number is supplied on the invoice.
4. Staff and consumables cost can only be charged if a patient has been treated.
5. A second patient is transferred at 50% reduction of the basic call and flight cost, but staff and consumables costs

GROUP B – EMERGENCY CHARTERS

1. No staff and equipment fee are allowed.
2. Cost will be reviewed per case.
3. Payment of emergency transport will only be allowed if a Group A aircraft is not available within an optimal time period for transportation and stabilisation of the patient.

		Practice Code		
CODE	DESCRIPTION OF SERVICE	13	11	9
		AMOUNT PAYABLE Payable		
5	AIR AMBULANCE: ROTORWING			
	Rotorwing Type A: Transport			
300	Basic call cost	--	--	11949.92
PLUS	Flying time			
301	Cost per minute up to 120 minutes Minimum cost for 30 minutes (R5704.18) applicable	--	--	190.14
302	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	190.14
303	Hot load (A very quick and rushed load into the aircraft usually at the accident scene), (per minute) – maximum 8 minutes (R1521.12)	--	--	190.14
	Rotorwing Type B and C (day operations): Transport			
310	Basic call cost	--	--	21002.69
PLUS	Flying time			
311	Cost per minute up to 120 minutes	--	--	328.09
	Minimum cost for 30 minutes (9842.85) applicable			
312	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	328.09
313	Hot load (A very quick and rushed load into the aircraft usually at the accident scene),(per minute) – maximum 8 minutes (R2624.76)	--	--	328.09
	Rotorwing Type B and C (night operations): Transport			
315	Basic call cost	--	--	29874.18
PLUS	Flying time			
316	Cost per minute up to 120 minutes	--	--	328.09
	Minimum cost for 30 minutes (R9842.85) applicable			
317	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	328.09
318	Hot load (A very quick and rushed load into the aircraft usually at the accident scene), (per minute) – maximum 8 minutes (R2624.76)	--	--	328.09
	Rotorwing Type A, B and C: Staff and consumables			
320	0 - 30 minutes	--	--	1852.93
321	31 - 60 minutes	--	--	3705.84
322	61 - 90 minutes	--	--	5558.95
323	91 minutes or more	--	--	7411.66
	Rotorwing Type D: Transport			
330	Basic call cost	--	--	25202.96
PLUS	Flying time			
331	Cost per minute up to 120 minutes	--	--	391.28
	Minimum cost for 30 minutes (R11738.35) applicable			
332	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	391.28
333	Hot load (A very quick and rushed load into the aircraft usually at the accident scene), (per minute) – maximum 8 minutes (R3130.23)	--	--	391.28
	OTHER COSTS			
340	Winching (per lift)	--	--	3231.36
6	AIR AMBULANCE: FIXED WING			
	Fixed wing Group A			
	(Tariff is composed of flying cost per kilometre and staff and equipment cost per minute).			
	Fixed wing Group A: Aircraft cost			
400	Beechcraft Duke	--	--	65.44
401	Lear 24F	--	--	74.28

402	Lear 35	--	--	**74.28**
403	Falcon 10	--	--	**85.91**
404	King Air 200	--	--	**68.06**
405	Mitsubishi MU2	--	--	**74.28**
406	Cessna 402	--	--	**41.32**
407	Beechcraft Baron	--	--	**35.68**
408	Citation 2	--	--	**56.43**
409	Pilatus PC12	--	--	**56.43**
	Fixed wing Group A: Staff cost			
420	Doctor – cost per minute spent with the patient Minimum cost for 30 minutes (R2675.83) applicable	--	--	**89.19**
421	ICU Sister – cost per minute spent with the patient Minimum cost for 30 minutes (R977.48) applicable	--	--	**32.58**
422	Paramedic – cost per minute spent with the patient Minimum cost for 30 minutes (R977.48) applicable	--	--	**32.58**
	Fixed wing Group A: Equipment cost			
430	Per patient – cost per minute Minimum cost for 30 minutes (R796.99) applicable	--	--	**26.57**
	Fixed wing Group B: Emergency charters			
450	Services rendered should be clearly specified with cost included. Each case will be reviewed and assessed on merit.			

COMPEASY ELECTRONIC INVOICING FILE LAYOUT

Field	Description	Max length	Data Type
BATCH HEADER			
1	Header identifier = 1	1	Numeric
2	Switch internal Medical aid reference number	5	Alpha
3	Transaction type = M	1	Alpha
4	Switch administrator number	3	Numeric
5	Batch number	9	Numeric
6	Batch date (CCYYMMDD)	8	Date
7	Scheme name	40	Alpha
8	Switch internal	1	Numeric
DETAIL LINES			
1	Transaction identifier = M	1	Alpha
2	Batch sequence number	10	Numeric
3	Switch transaction number	10	Numeric
4	Switch internal	3	Numeric
5	CF Claim number	20	Alpha
6	Member surname	20	Alpha
7	Member initials	4	Alpha
8	Member first name	20	Alpha
9	BHF Practice number	15	Alpha
10	Switch ID	3	Numeric
11	Patient reference number (account number)	10	Alpha
12	Type of service	1	Alpha
13	Service date (CCYYMMDD)	8	Date
14	Quantity / Time in minutes	7	Decimal
15	Service amount	15	Decimal
16	Discount amount	15	Decimal
17	Description	30	Alpha
18	Tariff	10	Alpha

Field	Description	Max length	Data Type
19	Service fee	1	Numeric
20	Modifier 1	5	Alpha
21	Modifier 2	5	Alpha
22	Modifier 3	5	Alpha
23	Modifier 4	5	Alpha
24	Invoice Number	10	Alpha
25	Practice name	40	Alpha
26	Referring doctor's BHF practice number	15	Alpha
27	Medicine code (NAPPI CODE)	15	Alpha
28	Doctor practice number -sReferredTo	30	Numeric
29	Date of birth / ID number	13	Numeric
30	Service Switch transaction number – batch number	20	Alpha

31	Hospital indicator	1	Alpha
32	Authorisation number	21	Alpha
33	Resubmission flag	5	Alpha
34	Diagnostic codes	64	Alpha
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

Field	Description	Max length	Data Type
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
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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