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GENERAL NOTICE

NOTICE 218 OF 2013

DEPARTMENT OF LABOUR

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT 1993 (ACT No. 130 OF 1993), AS AMENDED

ANNUAL INCREASE IN MEDICAL TARIFFS FOR MEDICAL SERVICES PROVIDERS, PHARMACIES, AMBULANCES AND HOSPITAL GROUPS

1. I, Nelisiwe Mildred Oliphant Minister of 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),I prescribe the scale of "Fees for Medical Aid" payable under section 76,inclusive of the General Rule applicable thereto, appearing in the Schedule to this notice, with effect from **1 April 2013**

2. The fees appearing in the Schedule are applicable in respect of services rendered on or after **1 April 2013** and **Exclude VAT**.

N M OLIPHANT
MINISTER OF LABOUR
DATE: 29/01/2013

GENERAL INFORMATION / *ALGEMENE INLIGTING*

THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

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

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

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

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

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

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

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

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

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

DIE WERKNEMER EN DIE MEDIESE DIENSVERSKAFFER

Die werknemer het 'n vrye keuse van diensverskaffer bv. dokter, apteek, fisioterapeut, hospitaal ens. *en geen inmenging met hierdie voorreg word toegelaat nie, solank dit redelik en sonder benadeling van die werknemer self of die Vergoedingsfonds uitgeoefen word. Die enigste uitsondering op hierdie reël is in geval waar die werkgewer met die goedkeuring van die Vergoedingskommissaris omvattende geneeskundige dienste aan sy werknemers voorsien, d.i. insluitende hospitaal-, verplegings- en ander dienste — artikel 78 van die Wet op Vergoeding vir Beroepsbeserings en Siektes verwys.*

Kragtens die bepalings van artikel 42 van die Wet op Vergoeding vir Beroepsbeserings en Siektes mag die Vergoedingskommissaris 'n beseerde werknemer na 'n ander geneesheer deur homself aangewys verwys vir 'n mediese ondersoek en verslag. Spesiale fooie is betaalbaar vir hierdie diens wat feitlik uitsluitlik deur spesialiste gelewer word.

In die geval van 'n verandering in geneesheer wat 'n werknemer behandel, sal die eerste geneesheer wat behandeling toegedien het, behalwe waar die werknemer na 'n spesialis verwys is, as die lasgewer beskou word. ***Ten einde geskille rakende die betaling vir dienste gelewer te voorkom, moet geneeshere hul daarvan weerhou om 'n werknemer wat reeds onder behandeling is te behandel sonder om die eerste geneesheer in te lig****. Oor die algemeen word verandering van geneesheer, tensy voldoende redes daarvoor bestaan, nie aangemoedig nie.*

Volgens die Nasionale Gesondheidswet no 61 van 2003 Afdeling 5, mag 'n gesondheidswerker of diensverskaffer nie weier om noodbehandeling te verskaf nie. Die Vergoedingskommissaris kan egter nie sulke behandeling goedkeur alvorens aanspreeklikheid vir die eis kragtens die Wet op Vergoeding vir Beroepsbeserings en Siektes aanvaar is nie. ***Vooraf goedkeuring vir behandeling is nie moontlik nie en geen mediese onkoste sal betaal word as die eis nie deur die Vergoedingsfonds aanvaar word nie.***

Dit moet in gedagte gehou word dat 'n werknemer geneeskundige behandeling op sy eie risiko aanvra. As 'n werknemer dus aan 'n geneesheer voorgee dat hy geregtig is op behandeling in terme van die Wet op Vergoeding vir Beroepsbeserings en Siektes en tog versuim om die Vergoedingskommissaris of sy werkgewer in te lig oor enige moontlike gronde vir 'n eis, kan die Vergoedingsfonds geen aanspreeklikheid aanvaar vir geneeskundige onkoste wat aangegaan is nie. Die

Vergoedingskommissaris kan ook rede hê om 'n eis teen die Vergoedingsfonds nie te aanvaar nie. Onder sulke omstandighede sou die werknemer in dieselfde posisie verkeer as enige lid van die publiek wat betaling van sy geneeskundige onkoste betref.

Neem asseblief kennis dat 'n ***gesertifiseerde afskrif van die werknemer se identiteitsdokument benodig word vanaf 1 Januarie 2004*** *om 'n eis by die Vergoedingsfonds aan te meld. Indien 'n afskrif van die identiteitsdokument nie aangeheg is nie, sal die eis nie geregistreer word nie en die dokumente sal teruggestuur word aan die werkgewer vir die aanheg van die ID dokument. Alle ander dokumentasie wat aan die kantoor gestuur word moet ook die identiteitsnommer aandui. Indien nie aangedui nie, sal die dokumentasie nie verwerk word nie, maar teruggestuur word vir die aanbring van die identiteitsnommer.*

Die bedrae gepubliseer in die handleiding tot tariewe vir dienste gelewer in terme van die Wet op Vergoeding vir Beroepsbeserings en Siektes, sluit BTW uit. Die rekenings vir dienste gelewer word aangeslaan en bereken sonder BTW.

Indien BTW van toepassing is en 'n BTW registrasienommer voorsien is, word BTW bereken en by die betalingsbedrag gevoeg sonder om afgerond te word.

Die enigste uitsondering is die "per diem" tarief vir Privaat Hospitale, wat BTW insluit.

Neem asseblief kennis dat daar tariewe in die kodestruktuur vir privaat ambulanse is waarop BTW nie betaalbaar is nie.

CLAIMS WITH THE COMPENSATION FUND ARE PROCESSED AS FOLLOWS •
EISE TEEN DIE VERGOEDINGSFONDS WORD AS VOLG GEHANTEER

1. New claims are registered by the Compensation Fund and the **employer is notified of the claim number** allocated to the claim. 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 • *Nuwe eise word geregistreer deur die Vergoedingsfonds en die **werkgewer word in kennis gestel van die eisnommer**. Navrae aangaande eisnommers moet aan die werkgewer gerig word en nie aan die Vergoedingskommissaris nie. Die werkgewer kan die eisnommer verskaf en ook aandui of die Vergoedingsfonds die eis aanvaar het of nie*

2. If a claim is **accepted** as a COIDA claim, **reasonable medical expenses** will be paid by the Compensation Commissioner • *As 'n eis deur die Vergoedingsfonds **aanvaar** is, sal **redelike mediese koste** betaal word deur die Vergoedingsfonds.*

3. If a claim is **rejected (repudiated)**, accounts 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. • *As 'n eis deur die Vergoedingsfonds afgekeur (**gerepudieer**) word, word rekenings vir dienste gelewer nie deur die Vergoedingsfonds betaal nie. Die betrokke partye insluitend die diensverskaffers word in kennis gestel van die besluit. Die beseerde werknemer is dan aanspreeklik vir betaling van die rekenings.*

4. If **no decision** can be made regarding acceptance of a claim due to inadequate information, the outstanding information will be requested and upon receipt, the claim will again be adjudicated on. Depending on the outcome, the accounts from the service provider will be dealt with as set out in 2 and 3. Please note that there are claims on which a decision might never be taken due to lack of forthcoming information • *Indien **geen besluit** oor die aanvaarding van 'n eis weens 'n gebrek aan inligting geneem kan word nie, sal die uitstaande inligting aangevra word. Met ontvangs van sulke inligting sal die eis heroorweeg word. Afhangende van die uitslag, sal die rekening gehanteer word soos uiteengeset in punte 1 en 2. Ongelukkig bestaan daar eise waaroor 'n besluit nooit geneem kan word nie aangesien die uitstaande inligting nooit verskaf word nie.*

BILLING PROCEDURE • *EISPROSEDURE*

1. The **first account** for services rendered for an injured employee (INCLUDING the First Medical Report) must be submitted to the employer who will collate all the necessary documents and submit them to the Compensation Commissioner • *Die **eerste rekening** (INSLUITEND die Eerste Mediese Verslag) vir dienste gelewer aan 'n beseerde werknemer moet aan die werkgewer gestuur word, wat die nodige dokumentasie sal versamel en dit aan die Vergoedingskommissaris sal voorlê*

2. Subsequent accounts must be submitted or posted to the closest Labour Centre. It is important that all requirements for the submission of accounts, including supporting information, are met • Daaropvolgende rekeninge moet ingedien of gepos word aan die naaste Arbeidsentrum. Dit is belangrik dat al die voorskrifte vir die indien van rekeninge nagekom word, insluitend die voorsiening van stawende dokumentasie

3. If accounts 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 Labour Centre. All relevant details regarding Labour Centres are available on the website www.labour.gov.za • *Indien rekenings nog uitstaande is na 60 dae vanaf indiening en ontvangserkenning deur die Vergoedingskommissaris, moet die diensverskaffer 'n navraag vorm, W.Cl 20 voltooi en EENMALIG indien by die Arbeidsentrum.* Alle inligting oor Arbeidsentrums is beskikbaar op die webblad www.labour.gov.za

4. If an account has been **partially paid** with no reason indicated on the remittance advice, a duplicate account with the unpaid services clearly marked can be submitted to the Labour Centre, accompanied by a WCl 20 form. (*see website for example of the form). • *Indien 'n rekening **gedeeltelik betaal** is met geen rede voorsien op die betaaladvies nie, kan 'n duplikaatrekening met die wanbetaling duidelik aangedui, vergesel van 'n WCl 20 vorm by die Arbeidsentrum ingedien word (*sien webblad vir 'n voorbeeld van die vorm)*

5. **Information NOT to be reflected** on the account: Details of the employee's medical aid and the practice number of the referring practitioner • ***Inligting wat NIE aangedui moet word** op die rekening nie: Besonderhede van die werknemer se mediese fonds en die verwysende geneesheer se praktyknommer*

6. Service providers **should not generate** • *Diensverskaffers **moenie die volgende lewer nie**:*

    a. **Multiple accounts** for services rendered on the **same date** i.e. one account for medication and a second account for other services • ***Meer as een rekening** vir dienste gelewer op **dieselfde datum**, bv. medikasie op een rekening en ander dienste op 'n tweede rekening*
    b. **Accumulative accounts** - submit a separate account for every month • ***Aaneenlopende rekeninge** –lewer 'n aparte rekening vir elke maand*
    c. **Accounts on the old documents** (W.Cl 4 / W.Cl 5/ W.Cl 5F) New *First Medical Report (W.Cl 4) and Progress / Final Medical Report (W.Cl 5 / W.Cl 5F) forms

are available. The use of the old reporting forms combined with an account (W.CL11) has been discontinued. **Accounts on the old medical reports will not be processed** • ***Rekeninge op die ou voorgeskrewe dokumente*** *van die Vergoedingskommissaris. Nuwe *Eerste Mediese Verslag (W.Cl 4) en Vorderings / Finale Mediese Verslag (W.Cl 5) vorms is beskikbaar. Die vorige verslagvorms gekombineer met die rekening (W.CL11) is vervang.* ***Rekeninge op die ou vorms word nie verwerk nie.***

*** Examples of the new forms (W.Cl 4 / W.Cl 5 / W.Cl 5F) are available on the website www.labour.gov.za •**
*** *Voorbeelde van die nuwe vorms* (W.Cl 4 / W.Cl 5 / W.Cl 5F) *is beskikbaar op die webblad www.labour.gov.za***

COMPENSATION FUND

SCALE OF FEES FOR PRIVATE HOSPITALS (57/58) (*PER DIEM* TARIFF) WITH EFFECT FROM 1 APRIL 2013

SCALE OF FEES FOR PSYCHIATRIC AND REHABILITATION HOSPITALS (55) (PER DIEM TARIFF) WITH EFFECT FROM 1 APRIL 2013

ACCOMMODATION

The day admission fee shall be charged in respect of all patients admitted as day patients and discharged before 23:00 on the same date.

Ward fees shall be charged at the full day rate if admission takes place before 12:00 and at the half daily rate if admission takes place after 12:00. At discharge, ward fees shall be charged at half the daily rate if the discharge takes place before 12:00 and the full daily rate if the discharge takes place after 12:00.

Ward fees are inclusive of all pharmaceuticals and equipment that are provided in the accommodation, theatre, emergency room and procedure rooms.

Note: Fees include VAT

	DESCRIPTION	PRACTICE CODE 57/58
1.1	**General Wards**	
H001	Surgical cases: per day	2326.80
H002	Thoracic and neurosurgical cases (including laminectomies and spinal fusion): per day	2326.80
H004	Medical and neurological cases: per day	2326.80
H007	Day admission which includes all patients discharged by 23:00 on date of admission	995.85
		PRACTICE CODE 55
H008	**General Ward for Psychiatric Hospitals (Inclusive fee**: Ward fee, Pharmaceuticals, Occupational Therapy)	1812.69
1.2	**General ward for Rehabilitation Hospitals**	
H010	General Rehabilitation ward (Inclusive fee: ward fee, general rehabilitaion management (Physiotheraphy, Doctors, Nursing, Occupational Theraphy, etc)	3887.02
H020	Private ward accommodation will be payable at the same rate as for a General Ward: per day	2326.80

	DESCRIPTION	PRACTICE CODE 57/58
1.3	**Special Care Units** Hospitals shall obtain a doctor's report stating the reason for accommodation in an intensive care unit or a high care ward from the attending medical practitioner, and such report including the date and time of admission and discharge from the unit shall be forwarded to the Commissioner together with the account. Pre-drafted and standard certificates of authorisation will not be acceptable.	
H201	Intensive Care Unit: per day	15596.99
H215	High Care Ward: per day	8048.77
2.	**Theatres and Emergency Unit**	
2.1	**Theatre and Emergency fees are inclusive of all consumables and equipment. The after hours fee are included in the normal theatre fee.**	
	Emergency fee Rule: Emergency fee - excluding follow-up visits.	
H301	For all emergencies including those requiring basic nursing input, e.g. BP measurement, urine testing, application of simple bandages, administration of injections.	558.54
H302	For all emergencies which require the use of a procedure room, e.g. for application of plaster, stitching of wounds.	1133.16
H303	Follow-up visits: The Compensation Fund. will imburse hospitals for all materials used during follow-up visits. No consultation or facility fee is chargeable. The account is to be billed as for fee for service.	
H105	Resuscitation fee charged only if patient has been resuscitated and intubated in a trauma unit which has been approved by the Board of Healthcare Funders.	4434.24
2.2	**Minor Theatre Fee** A facility where simple procedures which require limited instrumentation and drapery, minimum nursing input and local anaesthetic procedures are carried out. No sophisticated monitoring is required but resuscitation equipment must be available.	

	DESCRIPTION	PRACTICE CODE 57/58
	The exact time of admission to and discharge from the minor theatre shall be stated, upon which the minor theatre charge shall be calculated as follows:	
H071	Charge per minute	67.29
2.3	**Major Theatre** The exact time of admission to and discharge from the theatre shall	
H081	Charge per minute	199.13

5.9	**Prosthesis** Prosthesis Pricing: **Note:** A ceiling price of R1035.76 per prosthesis is included in the theatre tariff. The combined value of all the components including cement in excess of R1035.76 should be charged separately. A prosthesis is a fabricated or artificial substitute for a diseased or missing part of the body, surgically implanted, and shall be deemed to include all components such as pins, rods, screws, plates or similar items, forming an integral part of the device so implanted, and shall be charged as a single unit. Reimbursement will be at the lowest available manufacturer's price (inclusive of VAT).	
H286	**Internal Fixators (surgically implanted)** Reimbursement will be at the lowest available manufacturer's price inclusive of VAT. Hospitals / unattached operating theatre units shall show the name and reference number of each item. The suppliers' invoices, each containing the manufacturer's name, should be attached to the account and the components specified on the account should appear on the invoice. **External Fixators** Reimbursement will be at 33% of the lowest available manufacturer's price inclusive of VAT.	
	DESCRIPTION	**PRACTICE CODE 57/58**
	Hospitals / unattached operating theatre units shall show the name and reference number of each item. The suppliers' invoices, each containing the manufacturer's name, should be attached to the account and the components specified on the account should appear on the invoice.	
5.10	**Medical artificial items (non-prosthesis)**	
H287	Examples of items included hereunder shall be artificial limbs, wheelchairs, crutches and excretion bags. Copies of invoices shall be supplied to the Commissioner. Reimbursement will be at the lowest available manufacturer's price inclusive of VAT. **Further Non-Prosthetic Medical Artificial items:** Sheepskins Abdominal Binders Orthopaedic Braces (ankle, knee, wrist, arm) Anti-Embolism Stockings Futuro Supports Corsets Crutches Clavicle Braces Toilet Seat Raisers Walking Aids Walking Sticks Back Supports Elbow / Hand Cradles	

5.11	**Serious Burns** Billed at normal fee for service. The following items are applicable and must be accompanied by a written motivation from the treating doctor.	
H289	Serious Burns: Fee for service (Inclusive of all services e.g. accommodation, theatre, etc.) except medication whilst hospitalised.	
H290	Serious Burns: Item for medication used during hospitalisation excluding the TTO's. ***Note**: TTO's should be charged according to item H288*	
5.12	**TTO**	
H288	TTO scripts will be reimbursed by the Commissioner for a period of two (2) weeks. A script that covers a period of more than two (2) weeks must have a doctor's motivation attached.	

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